House of Representatives

The House met at 10 a.m. and was called to order by the Speaker.

PRAYER

The Chaplain, the Reverend Daniel P. Coughlin, offered the following prayer:

Lord God, why is global security so difficult to achieve or sustain? Why is global security so needed and so desired? What do we mean when we say these words? How do we pray or even imagine what global security would look like?

So far, beyond our day-to-day world, the round of an agriculture cycle, the ordinary manufacturing routine, the busy swirl of business, economic free-fall, or the data of any computer, is the unimaginable picture of global security so impossible to communicate?

No wonder we are not sure what steps to take if we do not have a picture in mind. How do we pray, except to lay the words themselves before You, O Lord, as if it were Your problem or of Your making and, so now, in need of Your healing power. To which part of the world’s prayer for global security is any of us willing to say amen, Lord?

Yet deep down we know You know. We need global security. Help us, Lord, in word, in deed, in heart—at least in prayer, be united as we pray for global security and together say: amen.

THE JOURNAL

The SPEAKER. The Chair has examined the Journal of the last day’s proceedings and announces to the House her approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

PLEDGE OF ALLEGIANCE

The SPEAKER. Will the gentleman from Texas (Mr. Poe) come forward and lead the House in the Pledge of Allegiance.

Mr. POE of Texas led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

ANNOUNCEMENT BY THE SPEAKER

The SPEAKER. The Chair will entertain up to 15 requests for 1-minute speeches on each side of the aisle.

OUR PRESENCE IN AFGHANISTAN NOT WANTED

(Mr. KUCINICH asked and was given permission to address the House for 1 minute.)

Mr. KUCINICH. Why are we still in Afghanistan? Al Qaeda’s been routed. Our occupation fuels a Taliban insurgency. The more troops we send, the more resistance we meet. If we want to be truly secure, we need to redefine national security to include financial security, because America has record debt, skyrocketing unemployment, huge trade deficits, record business failures, and foreclosures.

The people of Afghanistan don’t want to be saved by us. They want to be saved from us. Our presence and our Predator drones kill countless innocents, create more U.S. enemies, and destabilize Pakistan. The U.S.-created Karzai government is hopelessly corrupt, despised by Afghans. Our solution: provide them with a high-level U.S. minder, making him less legitimate. Another strategy: buy or rent friends among would-be insurgents. Give them cash and guns. When the money runs out, they shoot at U.S. soldiers.

We played all sides in Afghanistan—and all sides want us out. They don’t want our presence, our control, our troops, our drones, our way of life. We’re fighting the wrong war in the wrong place at the wrong time. What part of “get out” do we not understand?

CONDITIONAL COMMITMENT

(Mr. POE of Texas asked and was given permission to address the House for 1 minute.)

Mr. POE of Texas. Madam Speaker, a war cannot be won from a podium, but it can be lost. Laying out our entire military strategy in Afghanistan for our enemies is not only unwise, but poses a significant threat to national security. Our enemies have proven to be patient and steadfast in their determination to wage war on democracy and freedom. The President will send more troops, but has shown his entire hand to the world.

Last night’s premature announcement by the President of an arbitrary end date for withdrawal contradicts our commitment to winning the war on terror—no matter how long it takes. It reaffirms our enemy’s belief that America will lose its will to win. It seems our policy in fighting the war in Afghanistan is the surge-and-retreat plan. Success should be the mission, not “get out of Dodge” on a certain date.

Nowhere in history has a nation told its enemy that commitment would be for a set period of time and then the struggle would be abandoned. The President has said he wants to avoid another Vietnam, yet he has reintroduced the Vietnam syndrome of conditional commitment to America’s cause.

And that’s just the way it is.

JOBS AND THE ECONOMY

(Mr. WILSON of Ohio asked and was given permission to address the House for 1 minute.)

Mr. WILSON of Ohio. Madam Speaker, I rise today to address the issue of key importance for my constituents:
H13390  CONGRESSIONAL RECORD — HOUSE  December 2, 2009

JOBS SUMMIT

(Mr. BACA asked and was given permission to address the House for 1 minute.)

Mr. BACA. Recently, a single parent in my district called my office for help. He lost his good-paying job and the health benefits that went with it. Sadly, he is not alone in this problem. More Americans than ever before are losing their jobs, their livelihood, and their homes. In California, the unemployment rate is 12 percent. In my area, the Inland Empire, unemploy-

DISPELLING HEALTH CARE MISINFORMATION

(Mr. GOHMERT asked and was given permission to address the House for 1 minute.)

Mr. GOHMERT. I need to dispel some of the misinformation that’s been put out about the health care bill that we passed in this House. For one thing, some have said, Well, States require you to have insurance on your car, so of course we can mandate that people buy health insurance. The bill we passed is not going to provide health insurance. It’s going to mandate—it does mandate—that you buy it, and if you don’t, if you’re above the poverty line, it won’t be provided. In fact, you have an extra income tax if you don’t buy the Cadillac insurance the government mandates.

If you want to know about the comparison, first of all, to States requiring car insurance, not one State in the country requires that a car—your own car—be insured. They require that you buy insurance to ensure against hurting another car or damaging another car. This is a whole different thing. We’re mandating that you buy insurance on your own car, your own vehicle, your own body. And that’s not constitutional.

WIDER WAR NOT A PATH TO PEACE AND SECURITY

(Mr. DOGGETT’ asked and was given permission to address the House for 1 minute.)

Mr. DOGGETT. Madam Speaker, I agree with so much of what President Obama said last night, but not so much what he would do. The path to peace and security will not be found through a wider war. Troop escalation by 40 percent, then de-escalation, all within 18 months, is totally unrealistic. We have been fighting in Iraq on the installment plan: a few more months, and many more billions. 2011 will not mark the

HONORING KEVIN LEE MITCHEM OF MATHEWS COUNTY, VIRGINIA

(Mr. WITTMAN asked and was given permission to address the House for 1 minute.)

Mr. WITTMAN. I rise today to pay tribute to Kevin Lee Mitchem. Kevin Mitchem was a proud Mathews County resident and a fervent supporter of public education, and he was committed to lending his time and knowledge to youth in the community. Kevin was a devoted husband to his beloved wife, Sara, and a dedicated father to their two children, Rachel and Daniel. As the owner of Mitchem Seafood, Kevin was a staunch supporter of watermen and the seafood industry.

At the time of his passing, Kevin Mitchem was the chairman of the Mathews County Board of Supervisors, and prior to the chairmanship he served for 12 years as a board member. Additionally, he served on the Middle Peninsula Planning District Commission.

Kevin was deeply involved in his community and dedicated much of his time and effort to serve the residents of Mathews County. Kevin Lee Mitchem was a true friend to all who knew him and will be greatly missed. He touched many people’s lives and the work that he did for his community will never be forgotten. My thoughts and prayers are with his family and friends.

HONORING MIAI-DAE POLICE DIRECTOR ROBERT PARKER

(Ms. ROS-LEHTINEN asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. ROS-LEHTINEN. I rise today to extend my sincere thanks to a distinguished south Floridian and a faithful public servant, Miami-Dade Police Director Robert “Bobby” Parker. For 33 years, he brought his community, it is truly with great sadness that we see him retired.

In 2004, Bobby’s long and successful career with the Miami-Dade Police Department culminated in the directorship of the department. Under his leadership, the department saw the implementation of unique and cutting-edge programs such as the Mortgage Fraud Task Force and the Gun Bounty Program. His vision and hard work have consistently had a profound and positive impact on all of south Florida.

He has always made his greatest efforts for the benefit of others and will be greatly missed by both the department and our community.

It is with pleasure that I join Bobby’s family, friends, and peers as they honor the many accomplishments of his outstanding career. Bobby’s lasting legacy will certainly be inspiring to countless officers to match his selflessness and performance.

I thank my good friend, Miami-Dade Police Director Bobby Parker, for all that he has done for our community in south Florida, and I truly wish him all the best in his years to come.

BRINGING A STRONG JOBS BILL

(Mr. ALTMIRE asked and was given permission to address the House for 1 minute.)

Mr. ALTMIRE. Madam Speaker, since our economy bottomed out in late winter and Democrats took bold and decisive action, the stock market has risen 4,000 points and America experienced its first positive GDP growth in 15 months. But more can be done and more must be done.

So as we recognize one of the most severe recessions in our Nation’s history, Democrats will focus on helping Americans on Main Street, not Wall Street. We will build upon the momentum we have created for positive growth in our economy and bring to the American Dream instead of the American Dream instead of fighting fingers and calling names, this is a time when we all need to be working together to find real solutions in creating jobs for the American people right here in the United States and not outsourcing those jobs outside of here.

For my part, I will host a jobs summit to hear from the private industry, nonprofit organizations, and labor organization and educators.

In the State of Ohio as we put America back to work.

JOBS SUMMIT

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end of this war. It will just mark the beginning of the next installment in what is a deteriorating 8-year war whose elusive end is always just over the horizon.

The better exit strategy is to have fewer troops. With some allies already prepared to take the lead, we can take positive steps of the blood split that remain American. We should honor the sacrifice of those courageously serving by putting fewer of them in harm’s way. It shouldn’t take 100,000 Americans to defeat 100 al Qaeda. All this effort props up a corrupt Karzai government that just stole over a million votes. Afghanistan can consume as many lives and as many dollars as we’re willing to expend there, and leave our families no safer.

STIMULATING OUR ECONOMY THROUGH ANOTHER JOBS BILL

(Mr. WU asked and was given permission to address the House for 1 minute to revise and extend his remarks.)

Mr. WU, Madam Speaker, to form a government that works, we need positive steps of the recession, and it is much less about what one is against than about what one is for. Who can forget that sense of free-fall in our economy last fall when we weren’t sure, those of us who had money in money market accounts, that we were going to get 100 pennies back on the dollar that we put into a bank. Who could forget the sense of free-fall in March or April when it wasn’t clear where our economy was ever going to go?

But this Congress and the administration stepped up to the plate. We passed a stimulus bill that cushioned the loss of jobs and is beginning to bring jobs back. More than half the Recovery Act money is still going to be spent into our economy. We passed a new unemployment extension benefit that will take effect and cushion the blow for working families.

But American families that have lost their jobs know that we need to do more, and we are going to do more. In contrast, Republicans have offered nothing. They voted “no” on creating jobs. We are going to say “yes,” and we are going to pass another jobs bill and stimulate our economy.

ENFORCE TRADE LAWS TO SAVE JOBS

(Mrs. DAHLKEMPER asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Mrs. DAHLKEMPER. Madam Speaker, many hardworking Americans are losing their jobs because of this recession. We must use every tool in our arsenal to help stop the loss of jobs and put Americans back to work.

Yesterday, I testified in front of the International Trade Commission, urging them to strictly enforce our antidumping and countervailing duty laws to protect American workers against unfair subsidies of steel tube products from China.

My constituents depend upon the ITC to enforce our laws and ensure that our trade partners play fair. As we look for more ways to create and save jobs, it is imperative that Congress and the Federal Government remain vigilant in our enforcement of our strong trade policies. We cannot allow any foreign producer to have an unfair advantage over U.S. workers. We owe it to our constituents to protect their jobs and enforce the laws that we have on the books.

CREATE JOBS BY CUTTING TAXES

(Mr. BURTON of Indiana asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BURTON of Indiana. I get a big kick out of my Democrat colleagues, for whom I have the highest respect. They’re talking about how they’re going to come up with a jobs bill. They’ve increased the debt this year by $1.4 trillion. They’re pushing through a health care bill, trying to ram it through, that’s going to cost $1 trillion to $3 trillion. They’re trying to push through a cap-and-trade bill that’s going to cost millions of jobs. And now, because they’re worried about whether they’re going to get reelected or not, they’re not talking about saying that they’re going to come up with another jobs bill.

What that means is another stimulus bill. The first stimulus bill did not work. It cost over $1 trillion when you include interest, and now they’re going to do it again. The way to create jobs is to take the heavy weight off the back of the American people by cutting their taxes and cutting business taxes like John F. Kennedy did and like Ronald Reagan did. If you do that, you’ll start seeing economic recovery—but not by blowing more money.

THE STIMULUS PLAN IS WORKING

(Mr. YARMUTH asked and was given permission to address the House for 1 minute.)

Mr. YARMUTH. Madam Speaker, despite mountains of evidence to the contrary, our Republican friends persist in saying “Bah, humbug,” whenever you talk about the stimulus effect. In fact, my constituent, Senator Mitch McConnell, yesterday on the Senate floor called the Recovery Act a failure.

Well, obviously he has been too busy obstructing the work of the Congress to go home and see what’s happening in his own community, because he ought to tell the people at GE’s Appliance Park that it’s a failure when 400 new jobs are coming back from China because of stimulus money; or the hundreds of people who are now working on renovating our interstate system, $30 million worth of work, courtesy of the American Recovery Act; or the 80 people who will be employed at the new maintenance center; or the 150 teachers who are still in the classrooms in Jefferson County Public Schools because of Recovery Act dollars.

Yes, we have plenty of work to do. There are too many people that are out of work, and we are committed to doing that, instead of saying, Bah, humbug, no, no, we won’t do anything. That’s the message we’re getting from the other side, but we will continue to work for the American people.

NATIONAL EPILEPSY AWARENESS

(Mr. CARNAHAN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. CARNAHAN. Madam Speaker, there is a condition in this country that affects more than 3 million people and sees 200,000 new cases every year; 25 percent are children. It’s epilepsy. It’s the third most common neurological disorder after Alzheimer’s and stroke. The cause is unknown in two-thirds of epilepsy cases. It can develop at any age. It can be a result of genetics, stroke, head injury, and other factors.

Earlier this year, I met a spirited 9-year-old from my district. Since the age of 7, Chad has been living with epilepsy and faces daunting challenges in school because of various misconceptions despite major improvements in diagnosis and treatment, epilepsy is often misunderstood and overlooked. Contrary to belief, it is not contagious. Some believe epilepsy is curable with medication or treatment when, in fact, over 80 percent of patients suffer uncontrollable seizures, despite treatment.

This is why raising awareness is so important. It will dispel myths and empower millions affected by this condition. I urge my colleagues to support further research, awareness, and education as we work together to find a cure for epilepsy.

A NATIONAL HOME RETROFIT PROGRAM WILL CREATE JOBS NOW

(Mr. WELCH asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WELCH. Madam Speaker, America faces two very serious challenges today. The first is an economy that continues to struggle. Too many Americans who want to work are out of work. The second is an energy policy that is failing. It’s not clean, it’s not sustainable, and it’s not affordable. We can address the jobs issue by taking on the challenge of a clean energy economy. We can create jobs. We can save homeowners money on their energy bills, and we can reduce our contributions to climate change. We can do that by investing in a national energy efficiency retrofit program.
Recently, 44 of my House colleagues and I wrote to President Obama, urging him to act now, to use his existing authority, to use already appropriated stimulus funds to build a national home retrofit program that will create jobs. Some call it Recovery Through Retrofit. Some call it Cash for Clunkers. I call it a sure-fire way to create jobs, and to create them now.

JOBS AND THE ECONOMY

(Ms. WATSON asked and was given permission to address the House for 1 minute.)

Ms. WATSON. Madam Speaker, Democrats have been focused on helping Main Street, not Wall Street, and momentum continues to build for additional job creation legislation. The Republicans created one of the worst recessions in history and did very little to help a recovery. The Republicans exacerbated the recession with tax cuts that favored the wealthy and did very little to help working people. Democrats acted to save the economy from falling apart, to facilitate a recovery and to put people to work.

We will build on the work we have done so far and save jobs and get this economy moving. More than half of the Recovery Act still must be spent into our economy, boosting it in the short term and laying a new foundation for long-term prosperity. New extensions of unemployment benefits have been taking effect that will inject demand into the economy. The first-time home-buyer tax credit, which has been extended, will be renewed in less than 2 weeks.

TIME TO END THE WAR IN AFGHANISTAN

(Ms. PINGREE of Maine asked and was given permission to address the House for 1 minute.)

Ms. PINGREE of Maine. $2.5 billion—that’s my State’s share of the wars we’ve been fighting for the last 8 years, and now this country is being asked to spend another $30 billion a year to send more troops to Afghanistan. It’s too much, Madam Speaker, for a war that just isn’t working.

At a time when we are struggling to put Americans back to work, we just can’t afford to escalate a war that we need to be winding down. At a time when we have asked our men and women in uniform to return to combat again and again, we cannot afford to send them back one more time to fight to protect a government that is now considered the second most corrupt on Earth. At a time when we are working to bring affordable health care to every family in this country, we just can’t afford to spend $1 million per soldier to occupy a country that doesn’t want us there.

Don’t be mistaken, Madam Speaker. When we need to protect our vital national interests, there is no cost too great, and the greatest Armed Forces in the world will rise to meet any challenge. But this is not the time to pay that price. This is a time to end this war and bring the troops home.

SUPPORT FOR SENDING MORE TROOPS TO AFGHANISTAN

(Mr. PENCE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. PENCE. After months of deliberation, the President announced yesterday his decision to endorse a request for reinforcements by our commanding officers in Afghanistan, and I support his decision. By calling for a surge of forces in Afghanistan, President Obama is embracing the counterinsurgency strategy that succeeded in Iraq and, if given a chance, will succeed again. The war in Afghanistan is a war of necessity. A decisive victory over the Taliban and al Qaeda must remain our unchanging objective.

Now while reinforcements are critical to achieving victory, the morale of our troops and the unequivocal support of those at home is also important. Our brave men and women in uniform need to know that those who send them into battle will stand by them until the battle is won. Congress should resist the temptation to impose artificial timelines for withdrawal or benchmarks, as they only demoralize our troops and embolden our enemies. Telling the enemy when your commitment to fight will run out is a prescription for defeat.

Congress should also reject any effort to pass a tax increase on the backs of our soldiers. Levying a war surtax at a time of runaway Federal spending is an insult to our men and women in uniform.

THE NEW CONGRESSIONAL TASK FORCE ON JOB CREATION

(Ms. TITUS asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. TITUS. Madam Speaker, with unemployment at a record high in southern Nevada, it’s critical that we focus our efforts on creating good jobs that will put Nevadans back to work. That’s why I’m proud to have recently introduced the New Congressional Task Force on Job Creation. This working group will collect innovative ideas and formulate legislation that will put people back to work across the country and get our economy moving again.

This effort is especially critical to strengthening our economy in southern Nevada. Creating jobs locally will require innovation in Nevada’s growing industries, such as renewable energy, and perhaps a high-speed train, as well as building a stronger national economy that puts people in the pockets of potential visitors who will come to Nevada and boost our travel and tourism industry.

I look forward to joining my colleagues on this task force in the coming weeks to find real solutions that will create jobs for Nevada and the rest of the country.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Ms. LORETTA SANCHEZ of California). Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX. Record votes on postponed questions will be taken later.

RECOGNIZING THE EXEMPLARY SERVICE OF THE 30TH INFANTRY DIVISION DURING WORLD WAR II

Mr. KISSELL. Madam Speaker, I move to suspend the rules and agree to the resolution (H. Res. 494) recognizing the exemplary service of the soldiers of the 30th Infantry Division (Old Hickory) of the United States Army during World War II, as amended.

The Clerk read the title of the resolution.

The text of the resolution is as follows:

H. Res. 494

Whereas the 30th Infantry Division of the United States Army was first activated in October 1917 and originally consisted of National Guard units from North Carolina, South Carolina, Georgia, and Tennessee;

Whereas, during World War II, the 30th Infantry Division landed at Normandy on June 14, 1944, participated in the advance across Northern France, joined the invasion of the German Rhineland, defended the Ardennes-Alsace, and fought to the final defeat of Germany in May 1945;

Whereas the 823rd and the 743rd Tank Destroyer Battalions were periodically attached to the 30th Division throughout its campaign in Europe;

Whereas the 30th Infantry Division played a key role in the breakout of the Allied forces from Normandy at St. Lo and the subsequent advance across France, Belgium, and the Netherlands;

Whereas the 30th Infantry Division was reorganized at Fort Jackson in 1941 for service in World War II, the division included two North Carolina National Guard infantry regiments, one Tennessee National Guard infantry regiment, and other elements;

Whereas, when the 30th Infantry Division was nicknamed Old Hickory in honor of General and President Andrew Jackson;

Whereas, when the 30th Infantry Division was reorganized at Fort Jackson in 1941 for service in World War II, the division included two North Carolina National Guard infantry regiments, one Tennessee National Guard infantry regiment, and other elements;

A. PRO TEMPORE

Whereas the 30th Infantry Division was recognized for its role in the defense of Mortain and St. Barthelemy, France, and Hill 317 against a German counterattack in August 1944, in actions in which three infantry regiments of the division (the 117th, 119th, and 120th) and a part of a fourth regiment and other elements of the division participated;

Whereas the 30th Infantry Division also played a key role stopping the German advance in the Battle of the Bulge and recaptured Maimedy and Stavelot and its vital bridge over the Ambleve River;

Whereas, in the report prepared for General Dwight D. Eisenhower by the American combat units that fought in the European Theater, the Army’s official historian,
This division was reactivated prior to World War II and served from the invasion of Normandy in which the 230th Field Artillery of the 30th Division came ashore on Omaha D-day-plus-1. The rest of the division came ashore D-day-plus-2. The units were reunited and extended until today with their actions in the days and weeks that followed our invasion of France.

In August of 1944, the much-anticipated German counterattack developed, and the Germans attacked in or near a town in France to where the 30th Division was at that point protecting our lines.

The generals from Eisenhower down, the Allied generals, had grown concerned that we were not moving quickly enough to secure the area of Normandy around our invasion beaches in a way that we could expand throughout France the way that we had anticipated and wanted. The German counterattack thus came with a certain amount of opportunity, because if we could hold off this counterattack, then it would create an opportunity for us to outflank the German Army, a maneuver that would eventually be called the St. Lo Breakout. It all depended upon if the 30th Division, the Old Hickory, could hold.

And the 30th Division, taking on the multiple panzer divisions of the German Army, did hold. They scattered into individual units and fought bravely for almost a week. They fought as our American soldiers have fought in our American service, achieving results without undue wastage of the lives of men who served in the 30th.

The commitment of the men of the 30th Division to make the sacrifices necessary to finish the mission to defeat an obvious threat to freedom and the security of the world should serve as an example and inspiration to us today. The Nation provided these men the resources necessary to win the war to which they were committed. And our soldiers, sailors, marines, and airmen have made the same commitment to this Nation today. We must heed the lessons to be learned from the 30th Division and today fully support our troops and their families with the resources necessary for them to finish the job in the wars America is fighting today.

I urge every Member to support this resolution.

Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. KISSELL. Madam Speaker, I thank my colleague from Virginia for his support and remarks.

The 30th Division, after its historic stand at the battle of Mortain, fought its way into Belgium in the heavy fighting that took place before the Battle of the Bulge. They fought in the Bulge of the Bulge, crossed the bridge at Remagen, and they shook hands with the Russians on the Elbe River at the end of the war.

The 30th Division has returned to its National Guard identification, centered mostly once again in North Carolina. The 30th, as I mentioned before, is currently in Iraq on its second tour of duty of service to this Nation. So the great tradition of the 30th, the Old Hickory Division, that began during World War I continues today as these men, women, and men, serve our Nation.

Madam Speaker, on a personal note, I would like to add that my father, Richard Henry Kissell, was a sergeant in the 30th Division, and the Army in the early part of 1941, and he was with the 30th all the way through. As a member of the 230th Field Artillery, he stepped ashore on the beaches of the Omaha D-day-plus-1, and all of these things we talked about, my father was there.

But he was just one of many that served our Nation in the 30th and all
the other forces during World War II that we call the “Greatest Genera-
tion,” that came back and did so much to make this Nation the great Nation that it continues to be today.

So it is with great pride and enthusiasm that I respectfully request the 30th Division and its relation to not only my State, to my family, but to the Na-
ton that I encourage all my colleagues to join in voting for House Resolution 494 honoring the 30th Division.

Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from North Carolina (Mr. Kissell) that the House suspend the rules and agree to the resolution, H. Res. 494, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. KISSELL. Madam Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to the rule XX and the Chair’s prior announcement, further proceedings on this motion will be postponed.

CONGRATULATING THE SAILORS OF THE UNITED STATES SUB-
MARINE FORCE

Mr. KISSELL. Madam Speaker, I move to suspend the rules and agree to the concurrent resolution (H. Con. Res. 129) congratulating the Sailors of the United States Submarine Force upon the completion of 1,000 Ohio-class bal-
listic missile submarine (SSBN) deterrent patrols.

The Clerk read the title of the con-
current resolution.

The text of the concurrent resolution is as follows:

H. CON. RES. 129

Whereas the Sailors of the United States Submarine Force have delivered completed the 1,000th deterrent patrol of the Ohio-class bal-
listic missile submarine (SSBN);

Whereas this milestone is significant for the Submarine Force, its crews and their families, the United States Navy, and the enti-
tire country;

Whereas this milestone was reached through the combined efforts and impressive achievements of all of the submariners who have participated in such patrols since the first patrol of USS Ohio (SSBN 726) in 1982;

Whereas as a result of the dedication and commitment to excellence of the Sailors of the United States Submarine Force, ballistic missile submarines have always been ready and vigilant, reassuring United States allies and deterring anyone who might seek to do harm to the United States or United States allies;

Whereas the national maritime strategy of the United States recognizes the critical need for strategic deterrence in today’s un-
certain world;

Whereas the true strength of the ballistic missile submarine lies in the extremely tal-
eted and motivated Sailors who have volun-
tarily chosen to serve in the submarine com-

 Substitute the word "cannot" with "will not be able to serve the ship as needed and to complete the mission."
For over 27 years, Ohio-class ballistic missile means, or SSBNs, have been our most survivable form of deterrence. As a result of the commitment to excellence by everyone associated with the SSBN program, our strategic missile submarines will always be a part of our Nation’s history. Today, these elite submarines remain on the front lines of freedom. Through their silent patrols, they will preserve peace for many years to come.

The success of the Trident program and the protection it continues to provide is a result of the sacrifices of a broad array of organizations and individuals; the submarine industrial base, which now employs over 80,000 people; the advancements in technology and highest quality equipment for these ships; the maintenance facilities and their technicians and engineers who work to a demanding timeline and under difficult sea-strait conditions to keep these boats ready for sea; the submarine training facilities which ensure that our sailors are trained and ready to perform their missions under any circumstances; and not least, the sailors and their families who dedicate their lives to supporting our Nation. Their sacrifice year after year is a large part of our Nation’s greatness.

Because I come from the Puget Sound region in the State of Washington, I have had the opportunity to watch the successes of the Trident submarine program from its inception. Back in 1972, the Navy decided that the Puget Sound would be the west coast home port for its newest class of strategic missile submarine, the Ohio-class SSBN.

In August 1982, the lead ship, USS Ohio, arrived on the Bangor waterfront to start a new life. Ohio was followed by seven more Trident boats, each taking up its responsibilities in this strategic defense of our Nation. Of the original 18 Trident SSBNs in the U.S. inventory, eight now call the Puget Sound their home and continue their crucial strategic deterrent role.

Additionally, after 24 years in operation, the first four SSBNs—Ohio, Michigan, Florida, and Georgia—have been converted into cruise missile submarines. Two of these platforms, Ohio and Michigan, continue their service from the Bangor submarine base in this new role. The remaining six Ohio-class SSBNs and two cruise missile submarines have always been ready from the naval submarine base at Kings Bay, Georgia.

It is truly fitting that we recognize the achievements of our Trident submarine and their families over the past 27 years. We look to them to continue to build upon their legacy of excellent service to the United States in the years ahead.

I want to thank my colleagues, Mr. KISSELL, Mr. WITTMAN, who have joined me in supporting this resolution; and I urge all of my colleagues to support it with their votes.

I would just add one thing: this is such an important program—and I have been part of the Defense Appropriations Subcommittee for 31 years—that we are now starting a follow-on to the Trident submarine program. And I can remember when we had great debates here in the House on whether we should do a service and whether we should have an MX missile. The one thing that we always understood is that the most survivable element of our strategic triad were these Trident submarines, and I commend Admiral Rickover and all of those who followed him for the great work that they did in inspiring these concepts, and it has been of great value to our country.

So I appreciate the gentleman from North Carolina yielding to me, and I appreciate you bringing this resolution to the floor. And I urge my colleagues to vote in favor of it. Thank you.

Mr. KISSELL. I would like to, at this point in time, thank my colleagues from Virginia (Mr. WITTMAN) and from Washington (Mr. DICKS) for their words about this resolution, the importance of this resolution.

This branch of service in the Navy, to the crews of the 14, these Ohio-class submarines, we offer our appreciation and thanks to the people that make it work, all of the listings of people that were given but especially to the friends and the families of these crew members that, without them and their support for these crews, it would make this work extremely much harder than what it is already during the times of separation and trials that exist upon the families.

This branch of service remains strong. It is a clear deterrent to those who seek to harm our Nation. We once again congratulate this branch of service on its 1,000th mission of deterrence and 1,000th successful mission. I reserve my time.

Mr. WITTMAN. I yield myself such time as I may consume.

Madam Speaker, I would like to thank again Mr. DICKS from the State of Washington and his leadership and his vision especially as we progress from the Ohio-class of submarine to the next generation. We know that right now the Ohio-class has been an integral part of the triad of the defense of this Nation. It is critically important that we plan now for the next generation of submarine that will eventually replace the Ohio-class.

And I applaud his vision, his leadership in recognizing the importance of the Ohio-class but also the efforts that make sure that we have that next class that provides for the defense of this Nation.

And I’d like to thank Mr. KISSELL, too, for his leadership and his recognition of the importance of the Ohio-class submarine and also the importance of the next class of the replacement for the Ohio-class for the future defense of this Nation.

With that, Madam Speaker, I have no other speakers, and I yield back my time.

Mr. KISSELL. Madam Speaker, at this point in time I would like to encourage all of my colleagues to join in voting “aye” on H. Con. Res. 129 to honor the Navy once again and the sailors in the Ohio-class submarines, the Ohio-class submarines, for its great work and successful 1,000 missions.

I yield back my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from North Carolina (Mr. KISSELL) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 129.

The question was taken. The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. KISSELL. Madam Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered. The SPEAKER pro tempore. Pursuant to clause 8 of rule X, the Chair’s prior announcement, further proceedings on this motion will be postponed.

MILITARY FAMILY MONTH

Mr. KISSELL. Madam Speaker, I move to suspend the rules and agree to the resolution (H. Res. 861) supporting the goals and ideals of National Military Family Month, as amended.

The Clerk read the title of the resolution.

The text of the resolution is as follows:

H. Res. 861

Whereas military families, through their sacrifices and their dedication to the United States and its values, represent the bedrock upon which the United States was founded and upon which the country continues to rely in these perilous and challenging times; and whereas the month of November, which includes the Veterans Day holiday, was declared by the President on October 30, 2009, to be Military Family Month: Now, therefore, be it

Resolved, That the House of Representatives—

(1) supports the goals and ideals of Military Family Month;

(2) recognizes the sacrifices and dedication of military families and their contributions to the United States; and

(3) commends the support and appreciation to the people of the United States who observed Military Family Month with appropriate ceremonies and activities.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from North Carolina (Mr. KISSELL) and the gentleman from Virginia (Mr. WITTMAN) each will control 20 minutes.

The Chair recognizes the gentleman from North Carolina.

GENERAL LEAVE

Mr. KISSELL. Madam Speaker, I request unanimous consent for Members to have 5 legislative days in which to extend and modify their remarks.
The SPEAKER pro tempore. Is there objection to the request of the gentleman from North Carolina?

There was no objection.

Mr. KISSELL. Madam Speaker, I yield myself such time as I may consume.

I would first like to recognize Congressman ROONEY from Florida for bringing this resolution to the floor. It is a very timely resolution and one that, while we recognize the importance of our military families all the time, we certainly want to have the opportunity to make it official, so to speak, for this Congress, this House of Representatives, to join in that recognition. So I thank Representative ROONEY for his efforts.

I also want to commend and thank President Obama for declaring November to be National Military Family Month as we support this resolution that will join in the goals and ideals that are set forth in this proclamation.

May I also note that we know that our military families are dedicated but also face great challenges and difficulties. As our troops have faced repeated deployments and have gone back into the field more often than perhaps we would like to see them there, we serve our countrymen, as we need for them to do, so much of the burden of this service falls back to the military family.

But the military families have responded in incredible ways. They unite around each other. They support each other. They help their single-parent families. They come together in a way not only to support themselves but to also support their family members that are deployed. It is not a surprise that this happens, because they are an extension of these men and women that serve our Nation so heroically.

So with this resolution, H. Res. 861, we simply want to recognize once again the work, the dedication, the sacrifice in honor of our families coming together and acknowledge this in a positive way from the U.S. House of Representatives.

I reserve my time.

Mr. WITTMAN. Madam Speaker, I yield to the gentleman from Florida (Mr. ROONEY) for as much time as he may consume.

Mr. ROONEY. Thank you, Mr. WITTMAN and Mr. KISSELL, for managing this bill and for Chairman SKELTON and Member McKox for supporting the National Military Family Month resolution.

This resolution is about supporting our military families. We rightly give due credit and time and again in this Chamber to our service men and women who wear the uniform, especially now in a time of war. But this bill goes a step further in recognizing the spouses and the parents and the children of those men and women who serve.

As a former Army captain married to another Army captain, my wife and I met so many families at just two of our duty stations at Fort Hood, Texas, and West Point, New York. The people that we came to know in the military were truly the best people we've ever met. The sacrifice of seeing a loved one off to war and waiting the days and months for their return, sending letters, making phone calls, and looking forward to a phone call or an email just to hear that they're okay; the sacrifice of moving time and time again and town to town and duty station to duty station when other families set down roots; and finally, the sacrifice of a mom and dad seeing their child putting on a uniform for the first time and marching at graduation and the pride that they feel, and sometimes even the sorrow of receiving a flag that draped their child's casket, this resolution honors them, moms and dads, the spouses, the children.

I urge Members to support this, and thank you for yielding, Mr. WITTMAN and Mr. KISSELL, and for supporting this bill.

Mr. KISSELL. Madam Speaker, I once again thank Representative ROONEY for bringing this resolution to the floor. And all of the ideals that I expressed, I think for the most part, I've had the opportunity to speak with many of our soldiers; and to a person, they tell me that if they just knew their families are being taken care of, what a relief that is for them to concentrate on the duty that we're asking them to perform in order to where the mission might be.

So once again, I ask for support for the resolution for a National Military Family Month, and I reserve the balance of my time.

Mr. WITTMAN. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I rise in strong support of House Resolution 861, which recognizes the goals and ideals of National Military Family Month. And I want to commend Representative Tom ROONEY of Florida for sponsoring this legislation.

Twenty years ago, the week of Thanksgiving was deemed Military Family Week as part of the Great American Family Project. And in 1996, with the support of the Armed Services YMCA, Military Family Week was expanded into Military Family Month. And Military Family Month seeks to recognize the sacrifices of our military families and the things they do for our Nation each and every day.

As we celebrate Veterans Day and Thanksgiving during the month of November, it is important that we celebrate the critical role of the military family.

During a time of extended conflict, it is imperative not only that we stop and take time to acknowledge the dedications and sacrifices made by our military families every day, but also that we pause to recognize the strength, commitment, and courage of the military spouse and children of our men and women serving today.

Whether deployed overseas or training at home, the families of our servicemen and -women are the foundation of our military and proudly represent a keystone in a strong national defense. Even though this resolution commends the sacrifices that our military families make, we should be grateful for their selfless service to America.

I urge Members to join me in support of this resolution and American military families.

I yield back the balance of my time.

Mr. KISSELL. Madam Speaker, I join with my colleague from Virginia in recognizing that the service and dedication of our military families is not just a 1 month deal; it is something that occurs every day, and we should recognize that every day. I ask my colleagues to support the resolution, H. Res. 861.

Mr. GINGRICH of Georgia. Madam Speaker, I rise today as a proud cosponsor of H. Res. 861, a resolution supporting the goals and ideals of National Military Family Month.

The families of those who serve our country on the front lines deserve our respect and appreciation of each and every citizen. These family members often watch our loved ones travel to faraway lands in support of a cause and an ideal so much greater than any one individual. The support given to our service men and women by their loved ones is irreplaceable, as it is the foundation for the bravery inherent in those who labor steadfastly in the defense of liberty.

The men and women of the United States armed services rely on the support and encouragement of their families to protect the liberties and freedoms we enjoy every day at home. From the service organizations that provide holiday gifts to the letter that a parent or sibling writes to a loved one deployed or stationed abroad, the love and support of our military families is paramount. The sacrifices performed by these families should never be forgotten or diminished because they represent the very foundation of the American spirit.

Let us also make certain that we remember those individuals who are in harm's way today in Iraq and Afghanistan, as well as those who have paid the ultimate sacrifice— we are forever grateful for your heroic acts and for your service to our nation.

The brave men, women, and families who have and continue to sacrifice for our present freedoms deserve our fullest support. These individuals represent our nation's finest qualities, and they must be treated with the utmost respect and honor. Recognizing the month of November as National Military Family Month is just one small token of our appreciation for the families and their sons, daughters, brothers, and sisters who labor steadfastly for the United States and its undying values of freedom and liberty for all. It is my hope that we continue to do all we can and more for the members of our Armed Forces and their families.

Madam Speaker, I urge all of my colleagues to support this resolution.

Mr. JOHNSON of Georgia. Madam Speaker, I rise today to applaud the actions of the House of Representatives in recognizing the burden which military families bear, and honoring the importance of the sacrifices they
make. I strongly support H. Res. 861, designating the month of November, which includes the Veterans Day holiday, as an appropriate time to observe National Military Family Month. As a Member of the House Committee on Armed Services, I find this resolution to be of great significance, and I urge my colleagues to support it.

Military families in my home State of Georgia have suffered the loss of 158 soldiers, 6 of whom were constituents in my district, as a result of military operations in Iraq and Afghanistan. Nationwide, military families have endured the loss of thousands of soldiers. We owe them our gratitude and recognition for their service. The men and women who serve in the Armed Forces are responsible for carrying out the invaluable task of keeping our country safe, and as they fulfill their duties at home and abroad, they rely, not only on the political support of fellow citizens, but also on the emotional support of their families. As we move forward with important military objectives in Iraq and Afghanistan, we should not forget this unseen, but crucial, support. Indeed, the dedication of military families represents what is finest about our country. And, with increasing military challenges, this resolution, honoring their commitment, will reaffirm the solidarity and unity that provides our country with strength and resolve as we pass through this time of tensions.

I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from North Carolina (Mr. KISSELL) that the House suspend the rules and agree to the resolution, H. Res. 861, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. KISSELL. Madam Speaker, I move to suspend the rules and to order the attendance of the Members of the House and that we proceed to the consideration of H. Res. 861 as amended.

The SPEAKER pro tempore. The Chair recognizes the gentleman from New York (Mr. GUTERIE) to offer an amendment.

Mr. GUTERIE. Madam Speaker, I ask unanimous consent for the insertion of the following amendment:

Resolved, That the House of Representatives —
1. recognizes the importance of teaching elementary and secondary school students, on Veterans Day and throughout the school year, the sacrifices that veterans have made throughout the history of the Nation and the wars and missions in which they fought; and
2. encourages elementary and secondary schools across the Nation to incorporate the sacrifices of veterans into their curriculum and to engage students in learning about, and honoring, the sacrifices that veterans have made.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New York (Mr. BISHOP) and the gentleman from Kentucky (Mr. GUTERIE) each will control 20 minutes.

The Chair recognizes the gentleman from New York.

Mr. BISHOP. Madam Speaker, I rise today in support of H. Res. 897 recognizing the importance of teaching elementary and secondary school students about the sacrifices that veterans have made throughout the history of the Nation. Over the recent Veterans Day holiday, I was proud to attend many ceremonies and parades held across my district to honor our veterans. Through these events and many others, students learn the important role past generations played in our Nation’s history. We watch with admiration the accomplishments of our servicemen and women, past and present. And as we come upon another holiday season, we are thankful for their perseverance and dedication, and are again reminded how important our military, their families, and veterans are to our Nation’s history and future.

Mr. BISHOP. Madam Speaker, I rise in support of H. Res. 897, and I thank my friend and colleague from Kentucky (Mr. GUTERIE) for offering this legislation. This resolution recognizes the importance of teaching elementary and secondary school students about the sacrifices veterans have made throughout our Nation’s history.

Our country is built on the backbone of men and women who served in our Nation’s military forces. Veterans from all across the Nation sacrifice their time, energy, and lives for freedoms that we sometimes take for granted. In 2008, there were over 23 million veterans in the United States, but much of our Nation’s youth do not fully comprehend the commitment our soldiers undergo on a daily basis. Many times, veterans leave combat and reintegrate into society with extreme challenges: post-traumatic stress disorder, alcoholism, drug abuse, and homelessness are just some of the afflictions our dear veterans face. However, there are a number of dedicated organizations that cater and focus direct attention to the needs of our veterans.

Last month, we commemorated our veterans on November 11 with Veterans Day. We remembered heroes for their fearlessness, their loyalty, and their dedication. Their selfless sacrifices continue to inspire us today as we work to advance peace and extend freedom around the world.

We also remember and honor those who laid down their lives in freedom’s defense. These brave men and women made the ultimate sacrifice for our benefit, and our country is forever indebted to our veterans for their courage and exemplary service.

But today, less than half of the Nation’s high school students have a basic knowledge of American history and the contributions veterans have made to our Nation’s safety and security; whereas fewer than half of the Nation’s high school seniors have a basic knowledge of American history and the contributions veterans have made to the Nation’s safety and security; and whereas elementary and secondary students have made throughout the school year, about the sacrifices that veterans have made throughout the history of the Nation; and

WHEREAS it is important for elementary and secondary school students, on Veterans Day and throughout the school year, about the sacrifices that veterans have made throughout the history of the Nation; and

There was no objection.

The Chair recognizes the gentleman from Kentucky.

Mr. GUTERIE. Madam Speaker, I yield myself such time as I may consume.

Mr. GUTERIE. Madam Speaker, I rise today in support of H. Res. 897 recognizing the importance of teaching elementary and secondary school students about the sacrifices that veterans have made throughout the history of the Nation. Over the recent Veterans Day holiday, I was proud to attend many ceremonies and parades held across my district to honor our veterans. Through these events and many others, students learn the important role past generations played in our Nation’s history. We watch with admiration the accomplishments of our servicemen and women, past and present. And as we come upon another holiday season, we are thankful for their perseverance and dedication, and are again reminded how important our military, their families, and veterans are to our Nation’s history and future.

I want to share one experience just a few weeks ago. We finished voting early, and I went for a walk around the Capitol on a beautiful fall day. As I was walking down the Mall, I walked past the World War II Memorial. I stood there, and there were older people looking at the Pacific side and the Atlantic side, and I was trying to think in my mind what they were thinking. Were they remembering a friend or colleague? That didn’t come back? A lot of them were sharing that experience with grandchildren or great-grandchildren. You could just see at the memorial the pride and the tears in our veterans.

As I continued to walk, I went down to the Korean war memorial, and that is one that my family has personal experience with. My uncle, 12 years before I was born, in 1932 was killed. And my grandfather and grandmother always talked about the sacrifice of veterans, particularly losing their oldest son in the Korean war.

Then further along the Mall there is the memorial to Abraham Lincoln with
the Gettysburg Address dedicating a cemetery to our veterans.

And then the one that is so moving, as I was walking back, the Vietnam Wall. As you see families at the Vietnam Wall, a lot of them will take a piece of paper, pencil and will sketch out the name of someone. As I was watching them doing that, I was standing there wondering, is that a husband that didn’t come home? Is that a father for a child they never met?

And then I turned back to get back for an evening meeting. As you head to the Capitol, you understand what it is all about. The thing that you see most and the story of this dome and this symbol is about freedom, and we wouldn’t have one without the other. It was an emotional day for me as I was walking back.

I have been talking to schools as I mentioned earlier during Veterans Day, and one of the things I talked to them about was about Francis Scott Key and ‘The Star-Spangled Banner’ and the history and the actual meaning of those words in that song. I always end it with—I will never pretend that I can improve on Francis Scott Key, but the last line, It is the land of the free, it is hope. But not just for us; it is hope for the world. People look to that dome throughout the world.

It hit me that the Mall is the story of veterans. And the reason the Mall is the story of veterans and memorializing veterans, this country, this Nation and this dome and this symbol is about freedom, and we wouldn’t have one without the other. It was an emotional day for me as I was walking back.

I have been talking to schools as I mentioned earlier during Veterans Day, and one of the things I talked to them about was about Francis Scott Key and ‘The Star-Spangled Banner’ and the history and the actual meaning of those words in that song. I always end it with—I will never pretend that I can improve on Francis Scott Key, but the last line, It is the land of the free, it is hope. But not just for us; it is hope for the world. People look to that dome throughout the world.

I urge my colleagues to support this resolution. While this resolution is new to the House, in closing, Madam Speaker, I have no further objection to the request of the gentleman from New York (Mr. Guthrie) that the House suspend the rules and agree to the resolution, H. Res. 897.

Mr. BISHOP of New York. Madam Speaker, on that I demand the yeas and nays. The question was taken.

The Speaker pro tempore. The question is on the motion offered by the gentleman from New York (Mr. Bishop) that the House suspend the rules and agree to the resolution, H. Res. 897.

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The Family Medical Leave Act has been a great program for working families in this country since it was passed in 1993. No one can question the benefit as provided for working women and men by being able to take time off from work to care for themselves or family members.

The intent of the law was to provide for 12 weeks of unpaid leave if an employee has worked 60 percent of a full-time schedule over the past year, which is about 1,250 hours. In order to qualify for coverage, therefore, an employee has to have logged in 1,250 hours over 12 months to be eligible. While 1,250 hours adequately reflects 60 percent of a full-time schedule for the vast majority of employees in this country, that equation does not work for flight attendants and pilots.

Flight attendants and pilots work under the Railway Labor Act rather than the Fair Labor Standards Act, which covers most 9 to 5 workers. Time between flights, whether during the day or on overnight layovers, is based on company scheduling requirements and needs but does not count towards crewmember time at work. Flight attendants and pilots can spend up to 4 to 5 days a week away from home and family due to the nature of their job. However, all those hours will not count towards qualification.

The courts have strictly interpreted the law and insisted that crewmembers must abide by the 1,250 hours for qualification even though the intent of the law was 60 percent of a full-time schedule.

A airline flight crews have been left out of what was intended to cover them. Therefore, a technical correction is needed to ensure that FMLA benefits are extended to these employees. This legislation seeks to clarify the intent of the law.

This legislation simply states that an airline crewmember will be eligible for FMLA benefits if they have worked or been paid at least 60 percent of the applicable total monthly guarantee or the equivalent for the previous 12-month period and a minimum of 504 hours.

In keeping with current law, any sick, vacation, or commuting time does not count towards the required number of hours. This brings these transportation workers in line with the intent of the original legislation, and as promised, when the law was first passed.

Last Congress, during an Education and Labor Committee hearing, we heard from Jennifer Hunt, a flight attendant for U.S. Airways. Jennifer was denied FMLA coverage when she applied to take time off to care for her ill husband, an Iraq war vet. Jennifer, unfortunately, like many other flight attendants and pilots as well, did not meet the hourly requirement.

I urge my colleagues to support this legislation so that flight attendants like Jennifer can qualify for the FMLA.

I reserve the balance of my time.

Mr. GUTHRIE. Madam Speaker, I yield myself as much time as I might consume.

Mr. BISHOP of New York. Madam Speaker, I rise in support of S. 1422, the Airline Flight Crew Technical Corrections Act. This bill is a companion to H.R. 912, which this House approved in February on a voice vote. The bill we consider today contains some of the changes that the House-passed legislation made in the other body and is equally deserving of support.

As we have heard, this legislation is needed to address a very narrow, very specific concern. At issue is the fact that some airline personnel are subject to a unique scheduling process in which they are paid for being on-call, but in some cases are not credited with those hours in the calculation used for Family and Medical Leave Act eligibility. The point is that this technicality is that some flight crew personnel may work a full-time schedule but fail to qualify for family and medical leave. This is a real concern for those grappling with health conditions or family obligations.

Many Members have been uneasy about efforts to open up the Family and Medical Leave Act for small changes when it is clear that broader reforms are necessary. The FMLA has worked well for 16 years, offering workers the flexibility to tend to their own health or care for a loved one in their time of need without fear of losing their job. But despite the law’s many successes, it has also become clear that changes are needed. The realities of today’s workplaces are different from those of a decade and a half ago. Courts have offered evolving interpretations, and, as is often the case with such a sweeping change to employment law, there have been unintended consequences for both employers and employees.

I know the majority has worked with Members on our side of the aisle to craft legislation carefully and avoid some of the pitfalls that could come with piecemeal reform of FMLA. I want to thank them for ensuring this bill does exactly what it intends, no more and no less. The bill before us today, in fact, clarifies further several narrow points contained in the House-passed bill and makes clear that these are truly technical corrections.

I hope Members will join me in supporting this bill and sending it to the President for his signature.

With that, I reserve the balance of my time.

Mr. BISHOP of New York. Madam Speaker, may I ask if the gentleman from Kentucky has any further speakers?

Mr. GUTHRIE. Madam Speaker, we have no further speakers, and with that, I yield back.

Mr. BISHOP of New York. Madam Speaker, let me just observe that we have been working on this bill now for approximately 2 years. I am delighted that we are now at the point where we are on the verge of passage and moving this bill to the President for his signature.

I urge my colleagues to support this legislation, and with that, I yield back the balance of my time as well.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. Bishop) that the House suspend the rules and pass the bill, S. 1422.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

Ms. WATERS. Madam Speaker, I move to suspend the rules and pass the bill (H.R. 320) to amend the National Manufactured Housing Construction and Safety Standards Act of 1974 to require that weather radios be installed in all manufactured homes manufactured or sold in the United States.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 320

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 “CJ’s Home Protection Act of 2009”.

SEC. 2. CONGRESSIONAL FINDINGS.

The Congress finds that—

(1) nearly 20,000,000 Americans live in manufactured homes, which often provide a more accessible and affordable way for many families to buy their own homes;

(2) manufactured housing plays a vital role in providing housing for low- and moderate-income families in the United States;

(3) NOAA Weather Radio (NWR) is a nationwide network of radio stations broadcasting continuous weather information directly to a nearby NWS Service (NWS) office, and broadcasts NWS warnings, watches, forecasts, and other all-hazard information 24 hours a day;

(4) the operators of manufactured housing communities should be encouraged to provide a safe place of shelter for community residents or a plan for the evacuation of community residents to a safe place of shelter within a reasonable distance of the community for use by community residents in times of severe weather, including tornados, floods, and wind, and local municipalities should be encouraged to require approval of these plans; and

(5) the operators of manufactured housing communities should be encouraged to provide a written reminder semiannually to all owners of manufactured homes in the manufactured housing community to replace the batteries in their weather radios; and

(6) weather radio manufacturers should include, in the packaging of weather radios, a written reminder to replace the batteries twice each year and written instructions on how to do so.

SEC. 3. FEDERAL MANUFACTURED HOME CONSTRUCTION AND SAFETY STANDARDS.

Section 604 of the National Manufactured Housing Construction and Safety Standards
Act of 1974 (42 U.S.C. 5403) is amended by adding at the end the following new subsection:

“(1) WEATHER RADIOS.—

“(A) REQUIREMENTS TO INSTALL WEATHER RADIOS.—The Federal manufactured home construction and safety standards established by the Secretary under this section shall require that each manufactured home delivered for installation shall be equipped with a weather radio inside the manufactured home that—

“(i) is capable of broadcasting emergency information relating to local weather conditions;

“(ii) is equipped with a tone alarm; and

“(iii) is equipped with specific Alert Message Encoding, or SAME technology.

“(B) LIABILITY PROTECTIONS.—No aspect of the function, operation, performance, capabilities, or utilization of the weather radio required under this subsection, or any instructions related thereto, shall be subject to the requirements of section 613 or 615 or any regulations promulgated by the Secretary pursuant to the authority under such sections.

“SEC. 4. ESTABLISHMENT.

“Not later than the expiration of the 90-day period beginning on the date of the enactment of this Act, the consensus committee established pursuant to section 604(a)(3) of the National Manufactured Housing Construction and Safety Standards Act of 1974 (42 U.S.C. 5404(a)(3)) shall develop and submit to the Secretary of Housing and Urban Development a proposed Federal manufactured home construction and safety standard required under section 604(c) of such Act (as added by the amendment made by section 3 of this Act) relating to weather radios in manufactured homes.

“SEC. 5. STUDY.

“The Secretary of Housing and Urban Development shall conduct a study regarding conditions and the acceptability of the requirement under the amendment made by section 3 of this Act (relating to supplying weather radios in manufactured homes) on the geographic location at which a manufactured home is placed, but only to the extent that such requirement applies to new manufactured homes. Not later than 18 months after the enactment of this Act, the Secretary shall submit to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives a report describing the results of the study to the extent that this study shall be conducted.

“The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from California (Ms. WATERS) and the gentleman from Virginia (Mr. WITTMAN) each will control 20 minutes.

“Ms. WATERS. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on this legislation and to insert extraneous material thereon.

“The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from California?

“There was no objection.

“Ms. WATERS. Madam Speaker, I yield myself as much time as I may consume.

“Madam Speaker, before I begin my remarks, I would like to thank the gentleman from Indiana (Mr. ELLSWORTH) for his continued leadership on this issue, and for authoring the legislation that is before us today.

“H.R. 320, the CJ’s Home Protection Act of 2009, is named after CJ Martin, a 2-year old boy who was killed during a tornado in southeast Indiana in 2005. His mother, Kathryn, helped pass a State law requiring the manufactured housing industry to install NOAA weather radios in all newly built units and spoke at the news conference in support of similar Federal legislation.

“Despite rapid advances in tornado warning technologies, residents of manufactured housing communities often do not have access to proper shelter. Many residents of manufactured homes have a place to go in the event of a tornado, whether it is a basement or an interior room. That is why Congress passed the Tornado Shelters Act, which was signed into law in 2005. That bipartisan bill authorized communities using community development block grant monies to construct or improve tornado-safe shelters located in manufactured housing parks. Unfortunately, this program is not used often enough.

“H.R. 320 represents the final link in protecting families and residents in these communities. These weather radios will get warnings out, sometimes as much as half an hour or more before the storm reaches the area, giving residents the ability to build shelters. Now we are going to give residents an opportunity to hear these warnings earlier so they can take shelter from these storms. The cost of installing these radios is minimal, and this is going to save lives.

“We will never go back and know whether CJ could have survived had this legislation been passed. We do know, though, by talking to people throughout the country that these radios have in many, many cases already saved lives and will save lives if we install them in manufactured housing. We have a shot at significantly reducing over half of the deaths from tornadoes simply by taking the step together and passing this legislation. I again want to commend the chairman and ranking member for expeditiously moving this legislation, and I commend the Member from Indiana (Mr. ELLSWORTH) for his thoughtfulness and his good passion and dedication to this issue.

“With that, Madam Speaker, I reserve the balance of my time.
Ms. WATERS. I yield such time as he may consume to the gentleman from Indiana, the author of this bill, Representative ELLSWORTH.

Mr. ELLSWORTH. Madam Speaker, I rise today in support of CJ’s Home Protection Act, H.R. 320. The House is considering the public safety legislation today—legislation which would require a NOAA weather radio be installed in all manufactured homes built and sold in this country—is a continuation of an effort we started 2 years ago. I introduced the bill in 2007. It passed by voice vote, and I hope it will receive broad support again today.

At 2 a.m. on the morning of November 6, 2005, an F3 tornado touched down in my district in southwest Indiana. The tornado hit a manufactured housing community after most people had gone to sleep, and it tragically took 25 lives, Hoosier lives in Vanderburgh and Warrick County. These lives might have been saved if the victims knew of the dangerous storm that was approaching.

CJ, a loving and playful 2-year-old boy, was one of the victims that night. CJ and 24 other victims, including his grandfather and great-grandmother, are the reason why I’m here today. His picture is a reminder of the heartbreaking loss that severe weather can bring to families and communities throughout this country. All too frequently, this loss comes with little or no warning.

Madam Speaker, I was the sheriff of the county back in 2005, and my department oversaw the recovery effort in the aftermath of this horrendous storm. The horror and devastation the storm left behind is something I will remember the rest of my life. That is why this bill is so important to me and many others.

While CJ is the inspiration for this important public safety legislation, Kathryn Martin, CJ’s mother, is the leader in the effort. In the months after the storm, Kathryn channeled her pain and suffering toward an effort to pass similar legislation in the State of Indiana. Kathryn would not be denied. She was successful in getting the bill passed, and because of the awareness she raised about weather radios, the people in my hometown of Evansville, Indiana, have the most weather radios in households per capita in the United States. When I first met Kathryn, I promised her that if I ever came to Congress I would introduce Federal legislation to do the same thing that she was trying to push in our State. The bill before us today is a fulfillment of that promise.

CJ’s Home Protection Act amended the Federal Manufactured Home Construction and Safety Standard to require that each manufactured home delivered for sale shall be supplied with a weather radio inside the manufactured home.

One might question that when not every area of the country endures the same dangerous tornado season, why should this be a national standard? While it’s true that some regions encounter more tornadoes than others, extreme weather exists everywhere. A tornado took CJ’s life. But for another child living in California, it could be a wildfire. If a child living in Texas, it could be a flash flood. Also, it should be added that NOAA weather radios are used to put out AMBER alerts. The radio must be capable of broadcasting emergency information, weather conditions, equipped with a tone alarm and specific alert message encoding, and comply with Consumer Electronics Association standards for public receivers.

Like a smoke detector, these inexpensive devices can provide families with the warning they need to take action and protect themselves when severe weather strikes. This bill is about improving public safety, plain and simple. It is about demonizing the manufactured housing industry. Kathryn and John Martin and the other residents of this community love their homes, and the manufactured houses provide affordable, high-quality homes for millions of families.

I’m a strong supporter of manufactured housing. I see this legislation as adding one more feature to enhance the safety features of these structures.

Before I conclude my remarks, Madam Speaker, I’d like to thank Chairman Barney Frank and his staff at the Financial Services Committee for their efforts to move this legislation forward. This bill would not be where it is today without the strong support of Ranking Member Spencer Bachus. He has been a vocal advocate for this cause from the very beginning.

Thank you very much. I would also like to thank Congressman Dennis Moore and Congresswoman Kay Granger for their support as original cosponsors. Finally, I’d like to thank my good friend from Indiana, Congressman Joe Donnelly, who was helpful throughout the entire process.

I urge my colleagues to support this important public safety legislation. The cost of a NOAA weather radio is a mere $30 to $80, and for that price we can improve the safety of so many people from the sudden threat of extreme weather.

Mr. WITTMAN. Madam Speaker, I yield myself such time as I might consume.

Madam Speaker, in closing, I do want to thank Ranking Member Bachus. He has done a tremendous job in pushing forth this bill, along with the chairman. And I also want to thank again Mr. ELLSWORTH for his passion and his leadership on this issue. We all know that we dread times of storm. We’ve just gone through one in Virginia where, luckily, we didn’t lose any lives. But we all know that we need to take action to prevent death and destruction, which is the purpose of this bill.

Mr. WITTMAN and the Committee, seeing the need, seeing where we can save lives, have been successful in getting the bill passed by voice vote, and I hope it will receive broad support again today. At 2 a.m. on the morning of November 6, 2005, an F3 tornado touched down in my district in southwest Indiana. The tornado hit a manufactured housing community after most people had gone to sleep, and it tragically took 25 lives, Hoosier lives in Vanderburgh and Warrick County. These lives might have been saved if the victims knew of the dangerous storm that was approaching.

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Mr. WITTMAN. Madam Speaker, I yield myself such time as I might consume.

Madam Speaker, in closing, I do want to thank Ranking Member Bachus. He has done a tremendous job in pushing forth this bill, along with the chairman. And I also want to thank again Mr. ELLSWORTH for his passion and his leadership on this issue. We all know that we dread times of storm. We’ve just gone through one in Virginia where, luckily, we didn’t lose any lives. But we all know that we need to take action to prevent death and destruction, which is the purpose of this bill.

Mr. WITTMAN and the Committee, seeing the need, seeing where we can save lives, stood up, assumed that leadership role and has really done, I think, a great thing for folks that have manufactured homes throughout the United States. Again, thank you for your leadership. And thank you again to Mr. Bachus, the gentlewoman from California (Ms. Waters), that she was trying to push in this House on this and to the chairman for pushing this important legislation through.

Mr. JOHNSON of Georgia. Madam Speaker, I rise today to applaud the actions of the House of Representatives in addressing the need to install weather radios in all manufactured homes manufactured or sold in the United States to ensure the safety of all Americans. This bill, named after a 2-year-old boy whose life was taken away when a tornado struck his community in 2005, will allow residents to receive more timely warnings about imminent severe weather. Accordingly, the bill ensures that each manufactured home delivered for sale in the United States is supplied with a weather radio.

Nearly 20,000,000 Americans live in manufactured homes. Because manufactured homes are more affordable than traditional homes, they are a viable housing option for low and moderate-income families. With the growth in the economy, manufactured homes have become a more affordable and affordable option for many families to purchase their own homes. Thus, weather radios are essential as they provide immediate broadcast warnings of severe weather, such as floods, tornadoes, and high winds.

In March of 2009 a surprise tornado struck the City of Atlanta and caused millions of dollars worth of damage. Tornadoes can strike in many parts of the country, including places where they are rare, such as Atlanta. This is why the CJ’s Home Protection Act of 2009 is an important piece of legislation that will save lives. I support this legislation and urge my colleagues to do the same.

Madam Speaker, I yield back the balance of my time.

Ms. WATERS. Madam Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore. The gentlewoman from California (Ms. Waters) that the House suspend the rules and pass the bill, H.R. 320.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

TEMPORARY FORBEARANCE FOR FAMILIES AFFECTED BY CONTAMINATED DRYWALL

Mr. WITTMAN. Madam Speaker, I move to suspend the rules and agree to the concurrent resolution (H. Con. Res. 197) encouraging banks and mortgage servicers to work with families affected by contaminated drywall to allow temporary forbearance without penalty on payments on their home mortgages, as amended.

The Clerk read the title of the concurrent resolution. The text of the concurrent resolution is as follows:

H13401

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CONGRESSIONAL RECORD — HOUSE
Whereas since January 2009 over 1,300 cases of contaminated drywall have been reported from 26 States and the District of Columbia;

Whereas noxious gases released from contaminated drywall can cause serious health effects involving the upper respiratory tract, such as bloody noses, rashes, sore throats, and burning eyes;

Whereas toxic fumes released from contaminated drywall can corrode metals inside the home, such as air conditioning coils and electrical wiring;

Whereas the dangers and health risks posed by contaminated drywall have forced thousands of families out of their homes and into temporary living situations, and many such families are unable to afford an additional financial burden;

Whereas because of cases of contaminated drywall, some Americans who pay their mortgages on time are now suffering from both financial problems and health complications at no fault of their own; and

Whereas banks and mortgage servicers can help families affected by contaminated drywall by taking into account, with respect to their mortgage payments, the financial burdens imposed by the need to respond to this public health emergency.

Resolved by the House of Representatives (the Senate concurring), That the Congress encourages mortgage servicers to work with families affected by contaminated drywall by considering adjustments to mortgage payment schedules that take these financial burdens into account.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from California (Ms. WATERS) and the gentleman from Virginia (Mr. WITTTMAN) each will control 20 minutes.

The Chair recognizes the gentlewoman from California.

General Leave

Ms. WATERS. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks in this section and to insert extraneous material thereon.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from California?

There was no objection.

Ms. WATERS. Madam Speaker, I yield to myself as much time as I may consume.

Madam Speaker, America's homeowners are currently facing the worst economic crisis in recent memory. Foreclosures are up. Home prices have declined and many homeowners now owe more on their homes than they are worth. These economic challenges have been made worse by health and safety issues many homeowners are now facing due to the installation of Chinese drywall in their homes. Since 2007, the Consumer Product Safety Commission has received over 2,100 reports from 32 States detailing health and safety problems associated with Chinese drywall. Problems include asth- ma attacks, headaches, irritated eyes and skin and bloody noses.

Regarding home safety, homeowners are seeing their appliances shut down and have witnessed the piping and wiring in their homes turn black from corrosion. This is because of the highly toxic chemicals that are in Chinese drywall. A recent CPSC study found high levels of hydrogen sulfide and formaldehyde in the air of homes built with Chinese drywall. As these are highly common and dangerous chemicals, the CPSC is advising homeowners with homes built with Chinese drywall to spend as much time outdoors and in the fresh air as possible. In the meantime, homeowners are desperate to remove these toxic building products from their homes. Some have even moved out of their homes in order to complete the repairs. Unfortunately, due to the current economic crisis, many families cannot afford to pay their mortgage and pay the rent on a second home.

The resolution before us today calls on the Nation's mortgage servicers to work with homeowners living in homes affected by Chinese drywall by providing a temporary forbearance of their mortgage payments in order to avoid the cost of renting a second home while their primary residence is treated.

Madam Speaker, this is a commonsense resolution. It's long overdue. As I mentioned, homeowners are dealing with the brunt of the economic crisis head on. Those dealing with Chinese drywall are especially vulnerable and need for their mortgage servicers to step up to the plate to assist them in dealing with this heavy burden.

I would like to thank the gentleman from Virginia (Mr. NYE) for offering this solution. I would like to note that the Senate has already passed a concurrent resolution and I hope that my colleagues in the House can show their support for America's homeowners by doing the same.

Madam Speaker, I reserve the balance of my time.

Mr. NYE. I yield myself such time as I may consume.

I'd like to thank my colleague from Virginia (Mr. NYE) for introducing this legislation, and I strongly urge my colleagues to support it.

Madam Speaker, I yield the balance of my time to the gentleman from Virginia (Mr. NYE).

Mr. NYE. I thank my colleague very much for yielding.

Madam Speaker, I stand here today to raise awareness about a problem affecting hundreds of families in Hampton Roads, Virginia, and thousands across the United States: the problem of toxic Chinese drywall. Chinese drywall has induced serious health problems, created severe financial hardships, and driven thousands of American families from their homes.

Since January 2009, over 1,300 cases have been reported from now over 26 States and the District of Columbia. I have seen firsthand the physical, emotional, and financial burden toxic Chinese drywall creates. Just the other month I visited homes in my district that had the drywall installed. The toxins released by the drywall reeked of rotten egg and had corroded the electrical wiring of the homes. In fact, there are homes that have had to replace expensive air conditioning units, televisions, microwaves, and other valuable appliances several times because of the harmful chemicals contained in the drywall.

Toxic Chinese drywall can also cause deep coughs, bloody noses, and severe

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ey irritation. And those are just the short-term health effects that we know about. I wouldn’t be surprised if even more serious health effects are soon found. Affected families have been left with an impossible choice: live in a home and put their family at risk, or sell the home for perhaps hundreds of thousands of dollars, to replace the drywall. While some more fortunate families have been able to get help from friends, relatives and neighbors, many others have moved into rental housing, forcing many more families into further hardship. These preliminary studies of corrosion of metal components taken from homes containing the problem drywall found copper sulfide corrosion in the initial samples tested, which supports the finding of an association between hydrogen sulfide and the corrosion. Ongoing laboratory tests continue to investigate the nexus between safety and the short- and long-term effects of such corrosion on the homes. Based on the studies completed to date, the interagency task force can begin a new phase by developing a protocol to identify homes with corrosive drywall and a process to address the corrosive drywall and its effects. I urge the task force to work expeditiously to complete the study phase and to release its protocols for identifying impacted homes and for remediation. This resolution will give homeowners the time they need to make decisions based on the Consumer Product Safety Commission studies and protocols for a more permanent solution to their situation. Mr. FORBES. Madam Speaker, I urge the Consumer Product Safety Commission to work with families affected by contaminated drywall, to allow temporary forbearance without penalty on payment on their home mortgages. I am a proud cosponsor of this Resolution. Along with thousands of affected homeowners across the country, my constituents are waiting for answers on the potential health and safety hazards posed by toxic drywall imported from China between 2004 and 2007. The corrosion of electrical wiring, home appliance failure, the emission of strong odorous gases, and the development of headaches, nausea, and throat irritation are just some of the commonly reported problems associated with Chinese drywall. Although a federal Interagency Task Force has been investigating this problem for nearly one year, suffering homeowners have still not been provided federal guidelines for inspection or remediation of their homes containing Chinese drywall. Basic questions remain unanswered, such as whether these homes are safe for people to reside in; whether Chinese drywall contains other common home fixtures or chemicals to cause additional harms. Homeowners continue to wait for answers from their government. Despite nearly 2,000 reported cases of Chinese drywall to the Consumer Product Safety Commission, and safety razors have not been reported, committees in the House of Representatives have yet to hold one investigative hearing on the matter. Members deserve the opportunity to hear from expert witnesses across the spectrum of this growing crisis. Health, financial, and safety issues must be explored in depth so that appropriate action may be taken on behalf of so many American homeowners and affected businesses.
More importantly, the task force has established an identification and remediation protocol team made up of scientists and engineers. While additional scientific studies continue, the most important next steps for the CPSC are to release the identification and remediation protocols. This will hopefully help homeowners who are already living in homes with the problems fixed so their homes are once again livable and up to par with market value.

I call on the CPSC and the task force to move quickly to identify and release these protocols as the most expedient manner possible. I urge the task force to work closely with homeowners and private industry to establish the most effective and efficient methods of identifying and fixing problem drywall.

On the finance side, I encourage lenders to work closely with homeowners to modify loans and extend credit for remediation once a protocol is established. The mortgage crisis of the past year would only be made worse by a new wave of people walking away from their mortgages over this issue. Any help lenders can provide in modifying loans, offering a period of forbearance, or providing credit will help more people to stay in their homes and prevent the banks from having to assume possession of homes which they will not be able to sell.

Mr. WEXLER. Madam Speaker, I rise today in support of House Concurrent Resolution 197, encouraging banks and mortgage servicers to work with families affected by contaminated drywall to allow temporary forbearance without penalty on payments on their home mortgages. As a founding co-chair of the Congressional Contaminated Drywall Caucus, I am proud to sponsor this resolution and support its passage, which sheds further light on the plight of thousands of homeowners in south Florida and around the Nation dealing with the “silent hurricane” of contaminated drywall in their homes.

The Congressional Contaminated Drywall Caucus, which now has 20 members from seven States, has been working diligently over the past year to ensure that the Federal agencies and relevant organizations in the private sector respond to the stake in this issue are engaged in a dialogue that produces a swift and complete response that provides relief to homeowners affected by this contaminated product. While I believe the response has not been nearly as swift as needed, I have been encouraged by recent efforts on the part of the Inter-Agency Task Force, led by Chairman Inez Tenenbaum of the Consumer Product Safety Commission, to come to a full determination of the science behind this problem, and from there determine the appropriate response to this array of issues that victims are facing on a daily basis.

One of these issues, and often one of the most critical for those affected, is maintaining their mortgage. As our economy begins to recover from the worst recession since the Great Depression and our housing market begins to show signs of life following record numbers of foreclosures, victims living in homes with contaminated drywall face the continued threat of foreclosure. These innocent victims are being forced to make the choice of remaining in their homes and paying their monthly mortgage at the risk of their own health and that of their family, or leaving their homes to find alternative housing. Should they choose to seek alternative housing, they are then responsible for both the mortgage on their contaminated home and the rent on their alternative housing.

House Concurrent Resolution 197 sends a strong statement on behalf of the entire House of Representatives that banks and mortgage lenders should work with families affected by this contaminated drywall to provide temporary forbearances on their mortgage, without penalties, to ensure victims have the ability to move their families out of harm’s way without risking their financial futures or losing their homes. Providing this relief is not only the right thing to do, but it is essential that families incurring affected families do not continue to put their health at risk from this defective product.

Madam Speaker, I am proud to support this resolution and encourage all of my colleagues to support this resolution.

Mr. WITTMAN. Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California (Ms. WATERS) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 197, amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Ms. WATERS. Madam Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair’s prior announcement, further proceedings on this motion will be postponed.

ENHANCED S.E.C. ENFORCEMENT AUTHORITY ACT

Mr. KANJORSKI. Madam Speaker, I move to suspend the rules and pass the bill (H.R. 2873) to provide enhanced enforcement authority to the Securities and Exchange Commission, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 2873

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 “Enhanced S.E.C. Enforcement Authority Act”.

SEC. 2. NATIONWIDE SERVICE OF PROCESS.

(a) Securities Act of 1933.—Section 22(a) of the Securities Act of 1933 (15 U.S.C. 77(a)(1)) is amended as follows:

(1) by inserting after the second sentence the following: “In any civil action instituted by the Commission under this title in a United States district court for any judicial district, a complaint may be served at any place within the United States. Rule 45(c)(3)(A)(ii) of the Federal Rules of Civil Procedure does not apply to a subpoena so issued.”;

(c) Investment Company Act of 1940.—Section 31 of the Investment Company Act of 1940 (15 U.S.C. 80a–31) is amended by inserting after the fourth sentence the following: “In any civil action instituted by the Commission under this title in a United States district court for any judicial district, a complaint issued to compel the attendance of witnesses or the production of documents or tangible things (or both) at any hearing or trial may be served at any place within the United States. Rule 45(c)(3)(A)(ii) of the Federal Rules of Civil Procedure does not apply to a subpoena so issued.”.

(d) Investment Advisers Act of 1940.—Section 214 of the Investment Advisers Act of 1940 (15 U.S.C. 80b–14) is amended by inserting after the third sentence the following: “In any civil action instituted by the Commission under this title in a United States district court for any judicial district, a complaint issued to compel the attendance of witnesses or the production of documents or tangible things (or both) at any hearing or trial may be served at any place within the United States. Rule 45(c)(3)(A)(ii) of the Federal Rules of Civil Procedure does not apply to a subpoena so issued.”.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Pennsylvania (Mr. KANJORSKI) and the gentleman from California (Mr. CAMPBELL) each will control 20 minutes.

Mr. CAMPBELL. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on this legislation and to insert extraneous material thereon.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Pennsylvania?

There was no objection.

Mr. CAMPBELL. Madam Speaker, I yield myself such time as the Chair may allow.

The Chair recognizes the gentleman from Pennsylvania.

The Clerk read the title of the bill.

H.R. 2873 enjoys bipartisan support and previously passed the House in a slightly different form as part of the Securities Act of 2008 in the 110th Congress. In the 111th Congress, we’ve also incorporated this commonsense legislative reform in the Investors Protection Act of 2009. The House Financial Services Committee recently approved the Investor Protection Act and that bill will come to the House floor in the near future as part of the broader financial services regulatory reform package.

The U.S. Securities and Exchange Commission currently has nationwide service of process of subpoenas in administrative proceedings. This bill will enhance the Commission’s enforcement

H13404

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The SPEAKER pro tempore. Is there objection to the request of the gentleman from Pennsylvania?

There was no objection.

Mr. CAMPBELL. Madam Speaker, I yield myself such time as the Chair may allow.

The Chair recognizes the gentleman from Pennsylvania.

The Clerk read the title of the bill.
program by allowing subpoenas to be served nationwide in civil actions brought by the agency in Federal court. Currently, the Commission can issue a subpoena only within the Federal jurisdictional district where a trial takes place within 100 miles of the city or town where the court sits. Witnesses to certain cases brought by the Commission are, however, often located outside of a trial court's subpoena range.

With the proliferation of Internet scams that are perpetrated in multiple States where the law has hobbled the Commission's ability to efficiently and effectively mount its cases. Unless witnesses volunteer to appear at civil trials, the Commission must take depositions where the witnesses are located and use their written or videotaped deposition testimony at trial. Because of the associated travel for numerous lawyers and associates that must be present, depositions are generally more expensive than having a witness attend a trial.

H.R. 2873 would fix this problem by allowing the Commission to have nationwide service of process just as it currently has for its administrative proceedings. These changes in subpoena procedures for civil cases would apply to the Securities Exchange Act of 1934, the Securities Exchange Act of 1934, the Investment Company Act of 1940, and the Investment Advisers Act of 1940. Nationwide service of process would produce a number of substantial advantages, including a significant savings in terms of travel costs and staff time.

During these difficult economic times, we need to ensure that Federal agencies operate more efficiently. Additionally, we need to ensure that the Commission maximizes its limited resources to investigate and resolve wrongdoing in our securities markets. H.R. 2873 achieves both of these important objectives.

Mr. Speaker, I move that the bill the House is considering today incorporates the recommendations of the Commission, the Justice Department and our colleagues on the House Judiciary Committee. The consensus legislation, therefore, not only has bipartisan support in the House but it also has support from within the administration and across committee jurisdictions in the House. In short, H.R. 2873 is a commonsense bill that will allow the U.S. Securities and Exchange Commission to operate more efficiently.

Madam Speaker, I again commend the gentleman from California for his work on these matters, and I urge my colleagues to support this bill.

I reserve the balance of my time.

Mr. CAMPBELL. Mr. Speaker, I yield myself such time as I may consume. I would like to thank my colleagues from Pennsylvania (Mr. KANJORSKI) for his support of this bill and his kind words about this legislation. I would also like to thank the Judiciary Committee for working with us on the Financial Services Committee to come up with language that is mutually acceptable and works for everyone on this bill.

In light of the recent Wall Street scandals with Bernie Madoff and Stanford and others, we think it's appropriate to grant the Securities and Exchange Commission some additional tools so that they need to fight fraud and corruption in the markets. As Mr. KANJORSKI suggested—and I won't repeat the details of the bill which he accurately described—but if you think about it, most of these SEC enforcement issues will involve investors and perhaps conspirators from all over the country. But yet under current law, the SEC only has the authority to subpoena someone if they live within 100 miles of the Federal courthouse in which the trial is held.

So this means that if they need witness testimony from a victim, from a co-conspirator, from someone involved with the investment, from someone who participated in the alleged crime or who was a victim of the alleged crime, they have to get a deposition from them if they live more than 100 miles outside of the courthouse. Those depositions can be costly, difficult to get, and they clearly are not as effective in a trial circumstance as a witness actually in the trial.

This bill would correct that and simply give the SEC the same enforcement capabilities, the same subpoena capabilities that many other Federal enforcement agencies have in similar circumstances.

So I appreciate the bipartisan support. I appreciate the comments. I reserve the balance of my time. Mr. KANJORSKI. Mr. Speaker, I have no further requests for time and yield back the balance of my time. Mr. CAMPBELL. I will yield back the balance of my time as well.

The SPEAKER pro tempore (Mr. BLUMENAUER). The question is on the motion offered by the gentleman from Pennsylvania (Mr. KANJORSKI) that the House suspend the rules and pass the bill, H.R. 2873, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed. A motion to reconsider was laid on the table.

EMERGENCY ECONOMIC STABILIZATION ACT OF 2008 AMENDMENT

Mrs. MALONEY. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1242) to amend the Emergency Economic Stabilization Act of 2008 to provide for additional monitoring and accountability of the Troubled Assets Relief Program, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

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

SECTION 1. ADDITIONAL MONITORING AND ACCOUNTABILITY FOR THE TROUBLED ASSET RELIEF PROGRAM.

Section 116 of the Emergency Economic Stabilization Act of 2008 (12 U.S.C. 5224) is amended by adding at the end the following subsection:

"(c) ADDITIONAL MONITORING AND ACCOUNTABILITY.—

"(1) Electronic database.—

"(A) In general.—The Secretary shall establish an electronic database to monitor the use of funds distributed under this title.

"(B) Sources of data.—The database established under subparagraph (A) shall include data from the following sources, to the extent such data is available, usable, and relevant to determining the effectiveness of the Troubled Asset Relief Program:

"(i) Regulatory data from any government source.

"(ii) Filing data from any government agency receiving regular and structured filings.

"(iii) Public records.

"(iv) News filings, press releases, and other forms of publicly available data.

"(v) Data collected under subparagraph (B) of subsection (a) of section 121 of the Emergency Economic Stabilization Act of 2008 (12 U.S.C. 5224), and to the Special Inspector General and the Comptroller General of the United States for the Troubled Asset Relief Program:

"(i) Filing data from any government agency on at least a daily basis all data that is relevant to determining the effectiveness of the Troubled Asset Relief Program in stimulating lending and strengthening bank capital, including regulatory filings and data generated by the use of internal models, financial models, and analytics; and

"(ii) compare the data in the database with other appropriate data to identify activities inconsistent with the goals of this title.

"(B) Future uses of funds.—If the Secretary determines that a recipient's use of funds distributed under this title is not meeting the goals of this title, the Secretary shall, in coordination with the appropriate Federal agencies, develop recommendations for better meeting such goals, and such agencies shall provide such recommendations to such recipient.

"(C) Administrative use of data.—The Secretary shall—

"(i) ensure that the database uses accurate data structures and taxonomies to allow for easy cross-referencing, compiling, and reporting of numerous data elements;

"(ii) ensure that the database provides for filtering of data content to allow users to screen for the events most relevant to identifying waste, fraud, and abuse, such as management changes and material corporate events;

"(iii) ensure that the database provides geospatial analysis capabilities;

"(iv) make the database available to the Comptroller General of the United States and to the Special Inspector General and the Congressional Oversight Panel established under sections 121 and 125, respectively, to provide them with accurate information on the status of the funds distributed under this title, including funds distributed through procurement contracts; and

"(v) collect from each agency on at least a daily basis all data that is relevant to determining the effectiveness of the Troubled Asset Relief Program in stimulating lending and strengthening bank capital, including regulatory filings and data generated by the use of internal models, financial models, and analytics; and

"(vi) compare the data in the database with other appropriate data to identify activities inconsistent with the goals of this title.

"(2) Meeting TARP goals.—

"(A) Determination by secretary; recommendations.—If the Secretary determines that a recipient's use of funds distributed under this title is not meeting the goals of this title, the Secretary shall, in coordination with the appropriate Federal agencies, develop recommendations for better meeting such goals, and such agencies shall provide such recommendations to such recipient.

"(B) Future uses of funds.—If the Secretary determines that the use of funds described in subparagraph (A) does not meet the goals of this title within a reasonable time after the recommendations communicated under such subparagraph, the Secretary shall modify other uses of funds distributed under this title to avoid similar problems in the future.
(3) PUBLIC ACCESS TO DATABASE.—The Secretary shall, subject to paragraph (4), adopt rules and procedures for public access to the database created by this subsection.

(4) PROTECTION AGAINST DISCLOSURE OF CERTAIN INFORMATION.—

(A) PROHIBITION.—A person or entity shall not disclose to the public information collected by the Secretary that is prohibited from disclosure by any Federal or State law or regulation or by private contract or that is considered to be proprietary.

(B) PROTECTION OF INFORMATION.—The Secretary shall implement reasonable measures to prevent the disclosure of information in violation of subparagraph (A).

(C) CIVIL PENALTIES.—A Federal officer or employee, or a contractor of any Federal agency or employee of such contractor, who intentionally discloses to the public or intentionally causes to be disclosed to the public information prohibited from disclosure by subparagraph (A), knowing that such information is prohibited from disclosure, shall be fined under title 18, United States Code, or imprisoned for not more than 1 year, or both.

(5) REGULATIONS AND PROCEDURES.—The Secretary shall establish regulations that appropriately allocate among the appropriate Federal agencies, promulgate regulations and establish any other procedures necessary to carry out this subsection.

(6) DEADLINES.—

(A) CONTRACT SERVICES.—Not later than 30 days after the date of the enactment of this subsection, the Secretary shall issue a request for proposal and award contract services as required by this subsection.

(B) OPERATION OF DATABASE.—The Secretary shall ensure that the database described in paragraph (4) is operational not later than 180 days after the date of the enactment of this subsection.

SEC. 2. REDUCING TARP FUNDS TO OFFSET COSTS OF COUNTERPARTY CHANGES.

Section 115(a)(3) of the Emergency Economic Stabilization Act of 2008 (12 U.S.C. 4522(a)(3)) is amended by striking "$700,000,000,000" and inserting "$700,000,000,000, as such amount is reduced by $1,293,000,000, outstanding at any one time and inserting "$700,000,000,000, as such amount is reduced by $1,293,000,000, outstanding at any one time”.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from New York (Mrs. MALONEY) and the gentleman from California (Mr. CAMPBELL) each will control 20 minutes.

The Chair recognizes the gentlewoman from New York.

Mrs. MALONEY. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks, including the legislation and to insert additional material.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from New York?

There was no objection.

Mrs. MALONEY. Mr. Speaker, I yield myself as much time as I may consume.

I rise in strong support of H.R. 1242, the TARP Accountability and Disclosure Act of 2009. This bill would require the Department of the Treasury to establish a database for tracking all TARP funds. The bill would create a database available to the public on the Internet that will track in real time the spending of funds in the Federal Government’s Troubled Asset Relief Program called TARP. If UPS can track millions of packages clear across the world on any continent at any time, we can certainly track where $700 billion in taxpayers’ dollars are gone. In fact, we have a duty to do so.

When TARP began, the Treasury Department never required the financial institutions it funded to explain what they did with the money. And over a year later, we still do not know. It is past time for us to have a system so that the American people can tell in real time, enhancing its value as a regulatory oversight tool and also as a preventative oversight tool. Taxpayers have a right to know how their tax dollars are being used. I believe that in order to ensure transparency, we should require the use of the technological tools that are available today.

Currently, TARP data are presented in filings with the Securities and Exchange Commission, Web sites, Federal Reserve registration data, the FDIC data, over-the-counter trades, and Commodities Futures Trading Commission data sources are not only housed in different agencies but are in incompatible systems and formats, making the material unusable. These agencies are unable to share the data with each other and to learn from it.

The bill, which I have coauthored with Representative Peter King and 42 of my colleagues, requires all relevant TARP data, including regulatory filings and public records, to be collected by the Department of the Treasury and put in a consistent standardized format so that TARP funds will be transparent and traceable. This bill would also provide the ability to monitor inconsistencies that may indicate waste, fraud, and abuse at all levels of the government and individual officer levels. By using tools that currently exist, individual filings and transactions can be pulled together to create a single view of an institution and provide better management and regulatory oversight.

The basic data elements would include but not be limited to the following: the capture and standardization of every transaction the institution is involved with, wherever possible, press releases and other sources of public data; counterparty filings; securities transactions; UCC filings in certain cases; and transaction data, including mortgages, debt issuance, and fund participation.

In the simplest terms, my bill allows the question to be answered, Where has the money gone? And this is a question that pundits and taxpayers ask every single day. Recently, Elizabeth Warren, who is one of the oversight regulators, testified before Congress that she had no idea where the TARP money is. This bill would change this. This bill would put safeguards in to ensure that propriety information about financial services companies is not disclosed, and this bill does not put any additional burden on industry. It merely puts in a usable form information that is already required by regulators.

There is broad support for this bill from close to 40 groups from across the political field, including the Center for Democracy and Technology, The U.S. Chamber of Commerce, the NAACP, and the Heritage Foundation.

Mr. Speaker, I ask unanimous consent into the Record the list of supporters from respective organizations.

Groups that have publicly endorsed the bill (or if a 501(c)3 support the “idea or policy goals” of the legislation since they cannot directly support a specific bill):

United States Chamber of Commerce; Center for Democracy and Technology; OMB Watch; Project On Government Oversight; Taxpayers for Common Sense; OpenTheGovernment.org; Institute for Policy Innovation; Competitive Enterprise Institute; NAACP; Mexican American Legal Defense and Education Fund (MALDEF); National Puerto Rican Coalition (NPRC); The Hispanic Federation; Information Technology Industry Coalition (ITC); Americans for Tax Reform; Center for Fiscal Accountability; 60 Plus Association; Alabama Policy Institute; American Shareholder Association; Americans for Limited Government.

Americans for Prosperity; Caesar Rodney Institute; Center for Individual Freedom; Center-Right Coalition of Florida; Coalition Opposed to Additional Spending & Taxes; Council for Citizens Against Government Waste; Grassroots Institute of Hawaii; Illinois Alliance for Growth; Illinois Policy Institute; Institute for Liberty; Maine Heritage Policy Center; Mississippi Center for Public Policy; National Taxpayers Union; Oklahoma Council of Public Affairs, Inc.; Pelican Institute for Public Policy; Pioneer Institute for Public Policy Research; Rhode Island Tea Party; Small Business Hawaii; The Aarons Company; Kentucky Progress; Citizens’ Voice for Property Owners.

As we have seen from this time last year, the lack of transparency in terms of hold-ups and the fact that we have not disclosed, and this bill does not put any additional burden on industry. It merely puts in a usable form information that is already required by regulators.

There is broad support for this bill from close to 40 groups from across the political field, including the Center for Democracy and Technology, The U.S. Chamber of Commerce, the NAACP, and the Heritage Foundation.

Mr. Speaker, I ask unanimous consent of the record that I place into the Record the list of supporters from respective organizations.

I reserve the balance of my time.

Mr. CAMPBELL. I yield myself as much time as I may consume.

As I've said, there are many of us who have been supportive, and particularly Chairman FRANK for his leadership and STENY HOYER for his support. I urge my colleagues to support this bill. It's past time that we put in a system so that the American people can tell in real time how their tax dollars are being used. I would add that I also believe that it would build confidence in the system, hopefully a confidence that will be managed in an appropriate way.

I reserve the balance of my time.
just about transparency, disclosure and sunshine. Last year, $700 billion of taxpayer money was made available in order to provide a rescue plan for the financial system, which was troubled at that time. We all know that much of this money has gone out, but that isn’t really news. The real news is that we don’t really know what it has gone to do, what it is actually being used for, where it is being employed.

Now there are those who will say that, well, because there are dollars, if you put dollars into a given financial institution, it will still actually help that institution. We don’t really know which dollar went to what, and I understand that that argument has some legitimacy. But the point of this bill is, let’s disclose and let’s make available what we do know. There is a lot of information out there, as the gentlelady from New York suggested, which is in multiple agencies and multiple places, and it’s just simply not available to Members of the House or to Members of Congress so that we can see how effective the determination of whether this money has, is, and will be used in a manner consistent with its original objective which was to stabilize the financial system.

This bill, what it really does is, as it says, to make available, ongoing, continuous and close to real-time updates of the status of funds distributed through a standardized electronic database. That’s something which technology today enables us to do, and it’s something we can do. Taxpayers and the Members of Congress have the right to see in order to better evaluate the use of these funds. So I stand in support of this bill.

I reserve the balance of my time.

Mr. KING of New York. Mr. Speaker, I have no further speakers. I would just like to say that the program’s effectiveness was testified in support of by economist Mark Zandi, who said, while TARP has not been a universal success, it has been instrumental to the stabilization of the financial system and bringing an end to the credit recession, but there are still serious criticisms of the program that should give us concern about its effectiveness, its cost, and how it can be improved. This bill that brings online transparency would move us in that right direction.

I am strongly in support of it, as well as many of my colleagues.

Having no further speakers, I yield back the balance of my time.

Mr. KING of New York. Mr. Speaker, today I rise in support of H.R. 1242, the TARP Accountability and Disclosure Act. As the lead Republican sponsor of this legislation, I have worked closely with Representatives Maloney and Cantor as well as Financial Services Committee Chairman Frank and Ranking Member BACHUS to bring this important bill to the House floor.

The Emergency Economic Stabilization Act, EESA, created the Troubled Asset Relief Program, TARP, which authorized the Treasury Department to buy $700 billion worth of troubled assets from financial institutions. This money has also been used by Treasury to purchase preferred stock from banks and other financially troubled companies, such as AIG, General Motors, and Chrysler, and in support of programs such as the Targeted Investment Program, Asset Guarantee Program, and Consumer and Business Lending Initiative and more.

While Congress did subsequently place additional conditions on how it could be spent, it has been rather difficult to follow and account for this vast amount of money.

It is also important that not only our government but also the American People know exactly where their taxpayer dollars are going for programs such as TARP. The TARP Accountability and Disclosure Act requires the creation of a database system within the Department of Treasury and provides for additional monitoring and accountability that will provide true transparency of how the TARP funds are used. This system would serve as an efficient mechanism for oversight, audits, and investigations. H.R. 1242 will also require that this database be made publicly available, allow for cross-referencing, filtering of data content, and geospatial analysis capabilities. The database must be made available to oversight bodies such as the Special Inspector General, the TARP Oversight Panel, the Government Accountability Office, and law enforcement.

Additionally, the Secretary of the Treasury must provide the public access to the database, while protecting information that is prohibited from disclosure under current law. Importantly, this legislation begins the implementation of these measures soon after the enactment, allowing for oversight to begin promptly.

Mr. Speaker, the list and diversity of organizations that support this legislation is long. The public demands accountability with regard to taxpayer dollars and this bill provides the necessary reforms to ensure that TARP funds are used properly. The dynamic database outlined by this legislation provides a valuable tool for oversight. By establishing a mechanism for oversight and investigative agencies to review TARP fund usage, we are ensuring accountability.

Mr. LANGEVIN. Mr. Speaker, I rise in strong support of H.R. 1242, which would provide additional and necessary monitoring of Troubled Asset Relief Program funds.

H.R. 1242 would create a database to easily track the status of distributed funds, making it easier for those overseeing the program to spot inconsistencies in spending and ensure the most effective use of the funding. It would also require the Treasury Department to adjust the future use of TARP funds if its intended goals are not being achieved.

Along with my constituents, I am deeply disappointed that the past administration did not adequately track how taxpayer money was spent to ensure that banks were using it for the intended purposes. Earlier this year, I was pleased to vote for legislation that had ensured TARP funding was spent responsibly and transparently in an effort to get the economy back on track. Unfortunately, this measure was not taken up by the Senate.

In order to stabilize our economy and get credit flowing again to families and small businesses, we need to fundamentally change the practices of the Troubled Assets Relief Program. By strengthening accountability and increasing transparency, this measure ensures that public resources are being spent correctly and wisely. I urge my colleagues to vote for this measure.

Mr. CAMPBELL. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the distinguished lady from New York (Mrs. Maloney) that the House suspend the rules and pass the bill, H.R. 1242, as amended.
The question was taken. The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mrs. MALONEY. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered. The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair’s prior announcement, following the yeas and nays, the yeas and nays were taken, as follows:

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Mr. Speaker, on rollcall No. 914 had I been present, I would have voted "yea."
December 2, 2009

CONGRESSIONAL RECORD — HOUSE

H13409

Mr. KISSELL. The House begins with a recognition of members of armed forces and their families.

MOMENT OF SILENCE IN REMEMBRANCE OF MEMBERS OF ARMED FORCES AND THEIR FAMILIES

The SPEAKER. The Chair would ask all present to rise for the purpose of a moment of silence.

So (two-thirds being in the affirmative) the rules were suspended and the concurrent resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The House has finished business.

The SPEAKER pro tempore. The Speaker has motioned the House to suspend the rules and agree to the resolution, (Mr. KISSELL) that the House suspend the rules and agree to the resolution, H. Res. 861, as amended.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 417, nays 0, not voting 17, as follows:

The gentleman from North Carolina (Mr. KISSELL) that the House suspend the rules and agree to the resolution, H. Res. 861, as amended.

The vote was 5-minute vote.

The House has finished business.

The House has motioned the House to suspend the rules and agree to the resolution, (Mr. KISSELL) that the House suspend the rules and agree to the resolution, H. Res. 861, as amended.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 417, nays 0, not voting 17, as follows:

The vote was 5-minute vote.
The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. Bishop) that the House suspend the rules and agree to the resolution, H. Res. 897.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 419, nays 0, not voting 15, as follows:

[Roll of Yeas—419]

[Roll of Nays—0]

[Roll of Not Voting—15]

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. McNamar) announced that the House had adopted the resolution by the Yeas and Nays recorded.
CONGRESSIONAL RECORD — HOUSE

H13411

December 2, 2009

The question was taken. The SPEAKER pro tempore, in the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

RECORDED VOTE

Mr. HARE. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 415, noes 0, not voting 19, as follows:

(Roll No. 918)

AYES—415

The Clerk read the title of the bill.

Mr. CUÉLLAR. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3980) to provide for identifying and eliminating redundant reporting requirements and developing meaningful performance metrics for homeland security preparedness grants, and for other purposes.

The Clerk read the title of the bill as follows:

jeanne

This Act may be cited as the “Redundancy Elimination and Enhanced Performance for Preparedness Grants Act”.

SEC. 2. IDENTIFICATION OF REPORTING REDUNDANCIES AND DEVELOPMENT OF PERFORMANCE METRICS FOR PERFORMANCE METRICS FOR HOMELAND SECURITY PREPAREDNESS GRANTS PROGRAM.

(a) In general.—Title XX of the Homeland Security Act of 2002 (6 U.S.C. 601 et seq.) is amended by adding at the end the following new section:

“SEC. 2023. IDENTIFICATION OF REPORTING REDUNDANCIES AND DEVELOPMENT OF PERFORMANCE METRICS FOR PERFORMANCE METRICS FOR HOMELAND SECURITY PREPAREDNESS GRANTS PROGRAM.

“(a) In general.—The Administrator shall, for grants under sections 2003 and 2004 and any other grants specified by the Administrator, submit a report to the appropriate committees of Congress by not later than 120 days after the date of the enactment of the Reduce Redundancy Elimination and Enhanced Performance for Preparedness Grants Act, and by October 1st every 2 years thereafter, that—

“(1) identifies redundant rules, regulations, and requirements, as reported by recipients of such grants, and includes a plan for eliminating such identified redundancies and requirements;

“(2) includes a plan for developing and improving the performance metrics required under section 2022(a)(4) for such grants; and

“(3) includes an assessment of each program under which such grants are awarded.

“(b) Plan requirements.—Each plan under subsection (a)—

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H. RES. 648

Mr. POE of Texas, Mr. Speaker. I ask unanimous consent to have my name removed from H. Res. 648.

Mr. Speaker, I demand a recorded vote on the question of whether the record should be taken and whether the rules should be suspended to permit consideration of the motions to suspend the rules today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX.

Record votes on postponed questions will be taken later.

REREDUNDANCY ELIMINATION AND ENHANCED PERFORMANCE FOR PREPAREDNESS GRANTS ACT

Mr. CUÉLLAR, Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3980) to provide for identifying and eliminating redundant reporting requirements and developing meaningful performance metrics for homeland security preparedness grants, and for other purposes.

The Clerk read the title of the bill as follows:

H.R. 3980

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 “Redundancy Elimination and Enhanced Performance for Preparedness Grants Act”.

SEC. 2. IDENTIFICATION OF REPORTING REDUNDANCIES AND DEVELOPMENT OF PERFORMANCE METRICS FOR PERFORMANCE METRICS FOR HOMELAND SECURITY PREPAREDNESS GRANTS PROGRAM.

(a) In general.—Title XX of the Homeland Security Act of 2002 (6 U.S.C. 601 et seq.) is amended by adding at the end the following new section:

“SEC. 2023. IDENTIFICATION OF REPORTING REDUNDANCIES AND DEVELOPMENT OF PERFORMANCE METRICS FOR HOMELAND SECURITY PREPAREDNESS GRANTS PROGRAM.

“(a) In general.—The Administrator shall, for grants under sections 2003 and 2004 and any other grants specified by the Administrator, submit a report to the appropriate committees of Congress by not later than 120 days after the date of the enactment of the Reduce Redundancy Elimination and Enhanced Performance for Preparedness Grants Act, and by October 1st every 2 years thereafter, that—

“(1) identifies redundant rules, regulations, and requirements, as reported by recipients of such grants, and includes a plan for eliminating such identified redundancies and requirements;

“(2) includes a plan for developing and improving the performance metrics required under section 2022(a)(4) for such grants; and

“(3) includes an assessment of each program under which such grants are awarded.

“(b) Plan requirements.—Each plan under subsection (a)—

Maloney  Perlmutter  Shimkus
Mannino  Perriello  Shuler
Marchant  Peters  Shuster
Markley (CO)  Peterson  Simpson
Markley (MA)  Petri  Sires
Marshall  Pingree (ME) Skeleton
Mather  Pitts  Slaughter
Matheson  Platts  Smith (NE)
Matsui  Poe (TX)  Smith (NJ)
McCarthy (CA)  Polis (CO)  Smith (TX)
McCarthy (CA)  Pomeroy  Smith (WA)
McClintock  Posner  Snyder
McDermott  Pouilly  Souder
McGovern  Rauner  Space
McHenry  Regel  Spratt
McKeon  Richter  Stark
McMahon  Rogers (AR)  Taylor
Michaud  Rogers (NV)  Thompson (CA)
Miller (FL)  Rogers (MI)  Thompson (MI)
Miller (MI)  Rohrabacher  Thornberry
Miller (NC)  Rooney  Tiahrt
Miller, Gary  Roskam  Titus
Miller, George  Ros-Lehtinen  Tonko
Minnick  Ross  Traficant
Mitchell  Rothman (NJ)  Turner
Molchoan  Royal-Allard  Upton
Moore (KS)  Roybal-Allard  Van Doren
Moore (WI)  Rangel  Velazquez
Moran (KS)  Rogers (OH)  Visclosky
Murphy (CA)  Ryan (OK)  Walden
Murphy, Patrick  Ryan (RI)  Walz
Murtha  Sanchez, Linda  Wamp
Nadler (NY)  Sanchez, Loretta  Watters
Napolitano  Sarbanes  Waters
Neal (MA)  Schakowsky  Watson
Neugebauer  Schiffer  Watson
Nunes  Schiff  Weller
Oberstar  Schmidt  Welch
Obey  Schock  Westmoreland
Olsen  Schrader  Whitfield
Oyen  Scott (GA)  Wilson (OH)
Owens  Scott (VA)  Wilson (NC)
Pallone  Sensenbrenner  Wittman
Pascarell  Sessions  Wolf
Pastor (AZ)  Shays  Young (FL)
Paul  Sheehy-Lehtinen  Young (PA)
Payne  Sheehy-Potter  Young (TN)
Pence  Sherman  Young (TX)

NOT VOTING—19

Aderholt  Deal (GA)
Barrett (SC)  Eshoo
Barrow  Garamendi  Gephardt
Bishop (UT)  Gonzales  Gephardt
Canter  McMorris  Gephardt
Capuano  Rodgers  Gephardt
Davis (AL)  Melconian

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during a recorded vote on motions to suspend the rules).

The SPEAKER pro tempore. Is there a quorum? Yes. The ayes have it.

The SPEAKER pro tempore. The question was taken.

The Speaker pro tempore. The SPEAKER pro tempore.

The Speaker pro tempore. The SPEAKER pro tempore.

The Speaker pro tempore. There is no objection to the request of the gentleman from Texas.

There was no objection.

Record votes on postponed questions will be taken later.

The Speaker pro tempore. Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX.

Record votes on postponed questions will be taken later.
“(1) shall be developed in coordination with State, local, tribal, and territorial governments; and
“(2) shall include a proposed timeline for actions to implement the plan.
“(c) PROGRAM ASSESSMENT REQUIREMENTS.—Each program assessment under subsection (a)(3) shall include—
“(1) a summary of the purpose, objectives, and performance goals, and of the key findings of the assessment;
“(2) an assessment of the quality of the program’s metrics, and the extent to which necessary performance data are collected;
“(3) a summary of how the program’s strengths and weaknesses are impacting or contributing to its failures or successes, including reasons for any substantial variation from the targeted level of performance of the program;
“(4) a description of the extent to which any trends, developments, or emerging conditions affect the need to change the mission of the program or the way that the program is being carried out;
“(5) an identification of the best practices used in the program for allocating resources in an effective and efficient manner that resulted in positive outcomes and the key reasons why such practices resulted in positive outcomes;
“(6) recommendations for program modifications to improve the results that the program achieves;
“(7) a summary of key results of the program assessment that support maximizing the amount of funds appropriated for the program; and
“(8) an assessment of the quality of customer service offered to recipients of funds under the program and a strategy for improving such service.”.

b) CLERICAL AMENDMENT.—The table of contents in section 1(b) of such Act is amended by adding at the end of the items relating to title XX the following new item:
“Sec. 2032. Identification of reporting redundancies and development of performance metrics.”.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas (Mr. CUÉLLAR) and the gentleman from Alabama (Mr. ROGERS) each had 15 minutes.

The Chair recognizes the gentleman from Texas.

Mr. CUÉLLAR. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to re-vise and extend their remarks and insert extraneous materials on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. CUÉLLAR. Mr. Speaker, I rise in support of this bill and yield myself such time as I may consume.

Mr. Speaker, Congress instructed FEMA to develop metrics that can be used to identify and close gaps in preparedness with homeland security resources. These include the Comprehensive Assessment System, the Target Capabilities List, and the State Preparedness Report.

Since 2006, Congress has mandated FEMA to measure the Nation’s level of preparedness, as well as the effectiveness of State and local homeland security grant programs administered by FEMA. Both the Post-Katrina Reform Act of 2006 and the 9/11 Act of 2007 require FEMA to develop metrics that can be used to identify and close gaps in preparedness with homeland security resources. These include the Comprehensive Assessment System, the Target Capabilities List, and the State Preparedness Report.

Unfortunately, the various preparedness metrics developed since 2006 have not been properly integrated by FEMA, resulting in duplicative reporting requirements that put an undue burden
on State and local governments. State and local homeland security grant programs are essential to achieving and maintaining preparedness capabilities, and they can be strengthened and improved with input from stakeholders and the establishment of sound performance metrics.

This bill seeks to improve the way grant programs are administered and managed by FEMA, and will ensure that Congress is informed of the ongoing planning at FEMA for improving measurements of preparedness and eliminating duplicative requirements placed on grantees.

I urge my colleagues to support the measure, and I yield back the balance of my time.

Mr. CUellan. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, as you heard, this is commonsense legislation that will streamline FEMA's efforts to enhance our Nation's preparedness and response capabilities. We're trying to do is to make sure that we get rid of any unnecessary rules and regulations that cause our local folks problems. Number two, we're also trying to make sure that we measure the results. If we're going to spend billions of dollars on grants, we've just got to make sure that we measure those particular results.

The bottom line is, Mr. Speaker, we're trying to focus on the customers, and the customers are the recipients of these grants. I certainly want to thank our ranking member, Mr. ROGERS. He's done an outstanding job there in the committee. I look forward to working with him not only on this legislation to make it law but certainly on other pieces of legislation. I urge all my colleagues to vote "aye."

Mr. THOMPSON of Mississippi. Mr. Speaker, I rise in support of H.R. 3980, the "Redundancy Elimination and Enhanced Performance for Preparedness Grants Act."

This legislation, introduced by Mr. CUELLAR, the Chairman of the Subcommittee on Emergency Communications, Preparedness and Response, requires FEMA to assess the performance of its homeland security grant program and work towards addressing any identified deficiencies.

The legislation was developed based on finding from an October subcommittee hearing where FEMA testified as to the status of the agency's efforts to establish performance measurements of preparedness grants program.

At the hearing, we learned that that FEMA's efforts to implement statutory performance metrics-related requirements are fragmented and poorly integrated. As a result, FEMA is unable to measure how the $29 billion in homeland security grants appropriated since 2002 have improved the nation's overall level of preparedness. Without these much needed performance metrics, FEMA continues to impose redundant grant reporting requirements on State and local governments including those in my home State of Mississippi.

Not only are these redundant reporting requirements costly and time-consuming for State and local officials to prepare, but there is significant evidence that, taken together, they still do not provide FEMA with information necessary to measure the return on investment from federal grants.

Although there have been some improvements in FEMA's administration of homeland security grants, such as the improvements in the grant guidance and technical assistance provided to State and local applicants, we still have a ways to go.

H.R. 3980 would complement these efforts by directing FEMA to work with State and local officials to identify and eliminate these redundant grant reporting requirements. Specifically, H.R. 3980 would eliminate much of the red-tape and improve the performance of FEMA grant programs. The bill requires FEMA to develop a strategy, with timelines, to establish performance metrics for its homeland security grants and provides direction to complete a program assessment of its homeland security grants. These steps are designed to improve the agency's performance, productivity and accountability to the taxpayers. It will also provide Congress with better information on FEMA's performance to allow us to conduct more effective oversight and ensure that taxpayer money is being used efficiently and effectively.

Again, thank you for the consideration of this important legislation.

Ms. RICHARDSON. Mr. Speaker, as a member of the Homeland Security Committee, I rise today in strong support of H.R. 3980, the Redundancy Elimination and Enhanced Performance for Preparedness Grants Act. This legislation directs FEMA to streamline its grants reporting process to make it more efficient and informative, and it eliminates redundant requests for information.

I would like to acknowledge Speaker PELOSI and Chairman THOMPSON for their leadership in bringing this important bill to the floor. I would also like to thank my colleague Congressman CUellan, who worked so hard authoring this important legislation holding FEMA accountable for our taxpayer dollars.

Mr. Speaker, on October 27, as a member of the Subcommittee on Emergency Communication, Preparedness, and Response, I heard testimony from both FEMA officials and state and local government officials about the need for the grants being studied. State and local officials, including the mayor of Los Angeles in my home state of California, urged the federal government to reconsider their use of this program. In the words of the mayor, "all the reports that it generates provide no guidance or value for assessing homeland security investments."

H.R. 3980 directs FEMA to identify and address the problems it is experiencing with grants reporting and tracking. This legislation responds to the concerns raised to Congresswoman CUellan and me by the mayor of Los Angeles about the FEMA grants reporting process. I am proud that this legislation addresses those concerns. When it comes to homeland security and taxpayer dollars, we simply cannot afford to be wasting time or taxpayer money. So I am pleased to champion H.R. 3980, which addresses this problem.

In conclusion, Mr. Speaker, I support this bill because it will make our grant process more efficient and informative. Redundant reporting requirements and duplicative grants and communities and organizations will be able to better focus on doing the work they need to do to keep our nation safe.

Mr. Speaker, I urge my colleagues to join me in supporting H.R. 3980.

Mr. CUellan. I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. CUellan) that the House suspend the rules and pass the bill, H.R. 3980, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. CUellan. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered. The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

ENHANCING SECURITY TO RAIL AND MASS TRANSIT LINES

Ms. JACKSON-LEE of Texas. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 28) expressing the sense of the House of Representatives that the Transportation Security Administration should, in accordance with the congressional mandate provided for in the Implementing Recommendations of the 9/11 Commission Act of 2007, enhance security against terrorist attack and other security threats to our Nation's rail and mass transit lines, as amended.

The Clerk read the title of the resolution.

The text of the resolution is as follows:

H. Res. 28

Whereas the Transportation Security Administration is uniquely positioned to lead the efforts to secure our Nation's rail and mass transit systems and other modes of surface transportation against terrorist attack as a result of expertise developed over six years of securing our Nation's commercial air transportation system; and

Whereas the Transportation Security Administration's National Explosives Detection Canine Team Program has furthered the Transportation Security Administration's ability to secure our Nation's transportation systems against terrorist attack by preventing and protecting against explosives threats; and

Whereas each weekday 11,300,000 passengers depend on our Nation's mass transit systems as a means of transportation; and

Whereas rail and mass transit systems serve as an enticing target for terrorists and terrorist organizations, such as Al Qaeda, as evidenced by the March 11, 2004, attack on the Madrid, Spain, rail system, the July 7, 2005, attack on the London, England, mass transit system, and the July 11, 2006, and November 26, 2008, attacks on the Mumbai, India, rail system; and

Whereas the Transportation Security Administration Authorization Act of 2009, which was passed by the House of Representatives on June 4, 2009, in an overwhelming and bipartisan manner, expresses Congress' commitment to bolstering the security of rail and mass transit systems; and

Whereas securing our Nation's rail and mass transit systems against terrorist attack and other security threats is essential due to their impact on our Nation's economic stability and the continued functioning of our national economy; now, therefore, be it

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. CUellan) that the House suspend the rules and pass the bill, H.R. 3980, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. CUellan. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered. The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.
Resolved, That it is the sense of the House of Representatives that the Transportation Security Administration should—

(1) continue to enhance security against terrorist attack and other security threats to our Nation’s rail and mass transit systems and other modes of surface transportation, including as provided for in the Implementation of the 9/11 Commission Act of 2007 (Public Law 110-53) and the Transportation Security Administration Authorization Act of 2009 (H.R. 2200 in the 111th Congress);

(2) continue development of the National Explosives Detection Canine Team Program, which has proven to be an effective tool in securing surface transportation systems against terrorist attack and professional relations with the traveling public; and

(3) improve upon the success of the Online Learning Center by providing increased personal and rail systems against terrorist attack and other security threats to our Nation’s rail and mass transit systems, with particular attention to the application of its training standards and the establishment of a reliable source of domestically bred canines;

(4) continue to secure our Nation’s mass transit and rail systems against terrorist attack and other security threats, so as to ensure the security of commuters on our Nation’s rail and mass transit systems and prevent the disruption of rail lines critical to our Nation’s economy.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from Texas (Ms. JACKSON-LEE) and the gentleman from Alabama (Mr. ROGERS) each will control 20 minutes.

The Chair recognizes the gentlewoman from Texas.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous material on the resolution under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Texas?

There was no objection.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in support of this resolution and yield myself such time as I may consume.

Mr. Speaker, House Resolution 28 expresses the sense of the House of Representatives that TSA should increase and enhance its efforts to secure rail and mass transit systems in ways that are consistent with the 9/11 Act and H.R. 2200.

Let me first of all say, Mr. Speaker, that in addition to this legislation, as we stand on the floor today and watch the actions in Afghanistan and Pakistan, as we see the world changing from Mumbai to Madrid, we recognize the crucialness of national security and homeland security. And so this legislation is to emphasize the importance of expanding our oversight and responsibility to the security of mass transit and rail transportation.

I introduced this resolution because deadlines in the 9/11 Act have passed without being satisfied, which is inexcusable given the risks faced by our Nation’s rail and mass transit systems. In addition, I authored H.R. 2200, the TSA authorization bill, which included several elements that sought to enhance TSA’s surface transportation efforts. This bill passed the House overwhelmingly bipartisan manner earlier this year. As we wait for our friends in the Senate to act on H.R. 2200, I believe that the House agreeing to this resolution recommitts to our goal of TSA securing these transportation systems.

Let me first of all acknowledge the professional men and women that work for the Transportation Security Administration. I am gratified to know that progress is being made of a new administrator for that agency. I have worked very hard in H.R. 2200 to focus on their professionalism. But they need tools and they need the tools that will allow us to focus on the security of these important elements of transportation, and, as well, the job engine of our community and our Nation.

Many Americans use mass transit. Many Americans use rail. Any irreversible, tragic terrorist act can impact the economy of this Nation. As we were reminded by the tragic events in Russia over the weekend and in other cities around the world over the last several years, rail and mass transit systems are prime targets for terrorist acts. When they’re shut down, the economy can shut down.

This resolution recognizes TSA as being uniquely positioned to lead Federal efforts to secure our Nation’s rail and mass transit systems, and recognizes the National Explosives Detection Canine Team Program as a valuable resource, which my friend from Alabama has worked on. I might also say that this effort today, this resolution, is also to save lives. As such, it is critical that TSA’s security efforts share our commitment to securing these systems.

I urge my colleagues to join me in supporting this resolution and send a message about the importance of protecting our people, our infrastructure, and our economy.

I reserve the balance of my time.

Mr. ROGERS of Alabama. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of H. Res. 28, sponsored by my friends and the gentlewoman from Texas (Ms. JACKSON-LEE). We know the Nation’s surface transportation systems are designed for accessibility and efficiency, making them vulnerable to terrorist attack. When hardening the transportation sector from terrorist attack, we must construct and finance a system of deterrence, protection and response that effectively reduces the possibility and consequences of another terrorist attack without unduly interfering with travel through our transportation systems.

In the 9/11 Act of 2007, Congress mandated that DHS take certain steps to enhance the safety of our Nation’s rail public transportation systems. More than 2 years later, a number of mandates have gone unmet by the department, and this resolution expresses the sense of Congress that DHS should actually implement those mandates. It is time for DHS to move beyond the transportation sector-specific plans that identify and evaluate risk, to implementing risk reduction measures.

This resolution resolves that TSA should continue to enhance the security of our Nation’s rail and mass transit systems, continue the development of the canine explosive detection program, and enhance on-line training programs. The resolution also takes special note that more attention is needed for school transportation systems.

With that, Mr. Speaker, I would urge my colleagues to vote for this, and yield back the balance of my time.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield myself such time as I may consume.

I’d like to thank the staff of the Homeland Security Committee, and as well, the staff of the Transportation Security Committee, Mike Beland, and acknowledge the chairman of the committee for working with me and acknowledging the importance of this particular amendment and this bill.

Let me just say, as I close, we have already enunciated the parameters of securing mass transit and rail. We understand that we are behind in that effort.

I know there are committed, dedicated members of the Homeland Security Department and efforts that are ready to go. We need to give them the tools that they can work with. Even over the last couple of days as we look at actions that may be at first glance perceived to be innocent individuals intruding into the parameters of the White House, we know we have to be on alert, because no action should be taken in a simple or, if you will, non-serious manner.

So I stand today to say that this legislation, though a resolution, is serious because it emphasizes a commitment for tools and saving lives. I am delighted that my colleagues on the committee, in a bipartisan manner, have supported this. I’d like to acknowledge the ranking member of this committee, Mr. Dent; and I ask my colleagues to support this legislation, Mr. Speaker.

I believe this is a critical issue. H. Res. 28 addresses the critical issue of surface transportation, and I encourage my colleagues to vote ‘aye.’
It has been nearly six months since this body overwhelmingly passed the legislation to authorize TSA's rail and mass transit security activities (H.R. 2200).

Unfortunately, to date, the Senate has failed to move on H.R. 2200. The Senate also has yet to confirm a new TSA Assistant Secretary to fulfill the rail and mass transit security mandates that Congress overwhelmingly approved in 2007, with the passage of the Implementing Recommendations of the 9/11 Commission Act.

Plainly, there is still much to be done to secure rail and mass transit systems in the United States from bombings like the ones that occurred in Russia over the weekend, and other acts of terrorism.

In remembrance of those events, as well as the bombings of passenger rail and mass transit systems across the country and to build on existing programs that have shown promise, this resolution recognizes TSA as being uniquely positioned to lead Federal efforts to secure rail and mass transit systems.

I urge my colleagues to join with me in supporting this resolution and reaffirming our strong commitment to strengthening the security of our rail and mass transit systems.

Ms. RICHARDSON. Mr. Speaker, I rise today in support of House Resolution 28, which expresses the sense of the House of Representatives' commitment to strengthening security of rail and mass transit systems.

I urge my colleagues to join with me in supporting this resolution and reaffirming our strong commitment to strengthening the security of our rail and mass transit systems.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I move to suspend the rules and allow debate on H.R. 2200.

I would like to acknowledge Speaker PELOSI and Chairman THOMPSON for their leadership in bringing this important resolution to the floor. I would also like to thank my colleague Congresswoman SHEILA JACKSON-LEE, who authored this resolution recognizing TSA and its programs and urging the Administration to expand upon programs with a proven record of success, such as the Online Learning Center.

Mr. Speaker, I urge my colleagues to join me in supporting H. Res. 28.

Ms. JACKSON-LEE of Texas. With that, Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Texas (Ms. JACKSON-LEE) that the House suspend the rules and agree to the resolution, H. Res. 28, as amended.

The question was taken. The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

CRIMINAL INVESTIGATIVE TRAINING RESTORATION ACT

Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3963) to provide specialized training to Federal air marshals.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3963

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 “Criminal Investigative Training Restoration Act.”

SEC. 2. FEDERAL AIR MARSHALS.

Section 44917 of title 49, United States Code, is amended by adding at the end the following:

“(e) Criminal Investigative Training Program.—

“(1) New employee training.—Not later than 30 days after the date of enactment of this Criminal Investigative Training Restoration Act, the Federal Air Marshal Service shall require Federal air marshals hired after such date to complete the criminal investigative training provided through the Federal Law Enforcement Training Center as part of basic training for Federal air marshals.

“(2) Existing employees.—A Federal air marshal who has previously completed the criminal investigative training program shall not be required to repeat such program.

“(3) Alternative training.—Not later than 3 years after the date of enactment of the Criminal Investigative Training Restoration Act, an air marshal hired before such date who has not completed the criminal investigative training program shall be required to complete a alternative training program, as determined by the Federal Law Enforcement Center, that provides the training necessary to expand the skills of Federal air marshals.

“(4) Authorization of Appropriations.—Not less than $3,000,000 is authorized to be appropriated for each of fiscal years 2010 and 2011 to carry out this subsection.

“(5) Savings Clause.—Nothing in this subsection shall be construed to reclassify Federal air marshals as criminal investigators.”

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from Texas (Ms. JACKSON-LEE) and the gentleman from California (Mr. DANIEL E. LUNGREN) each will control 20 minutes.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous material on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Texas?

There was no objection.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in support of this bill and yield myself such time as I may consume.

First of all, I am grateful to the gentleman from California (Mr. DANIEL E. LUNGREN), who I have worked with before, who’s worked tirelessly on this issue. I am honored to be a cosponsor of this important legislation, and I do applaud his work.

This legislation will help to bolster the effectiveness and morale of the Federal Air Marshal Service, many of whom I visited with over my tenure as a member of the Homeland Security Committee. In my position as chairwoman of the Subcommittee on Transportation Security and Infrastructure Protection, I have promoted the need to keep our modes of transportation secure and to ensure that employees of the Department of Homeland Security have professional growth opportunities and are treated fairly and given the opportunity to exercise their concern and have this Congress and this executive listen to their concerns. This bill works towards both of these important objectives.

The Federal Air Marshal Service had to quickly expand its efforts in the wake of attacks on September 11, 2001. This bill helps to restore more training measures in a way that is consistent with that necessary expansion. In addition, this legislation provides for potential promotion opportunities.

I was pleased to see that consistent language to ensure that it would not adversely impact the salaries and benefits of Federal air marshals. Working
with the gentleman from California, as we have promised, we were able to agree on language that eliminates my concern. I thank the gentleman for his cooperation and collaboration for a very important step forward. Accordingly, I’m confident that Federal air marshals who help to keep us safe. This increased bill that will improve the security of the traveling public.

I look forward to the bipartisan passage of H.R. 3963 and reserve the balance of my time.

Mr. DANIEL E. LUNGREN of California. Mr. Speaker, I yield myself such time as I may consume. I thank the gentlelady for her gracious comments and her support of this bill. I rise in support of H.R. 3963, the Federal Air Marshals Criminal Investigative Training Restoration Act, a bill that I have authored.

Prior to 9/11, the criminal investigative training program at the Federal Law Enforcement Training Center was an essential part of the training that we have for our Federal air marshals, commonly referred to as FAMs. The events of 9/11, however, necessitated an emergency situation in which we were required to rapidly hire, train, and deploy thousands of new FAMs.

In order to meet these ambitious deployment mandates, the newly hired members of this corps, without prior Federal law enforcement experience, were not required to take the criminal investigative training program. It was not because we did not wish them to have it, but that would have delayed their deployment, and we were under an emergency situation. We realized that additional Federal air marshals were essential to the overall response to the threat we then knew to be real.

It has always been the intent of the Federal Air Marshal Service, however, to resume using the criminal investigative training program as part of the basic training for FAMs. This bill will restore the criminal investigative training program as part of the basic training for the members of this organization.

Crucial to the mission of the Federal air marshals is the ability to detect, deter, and prevent terrorists or other criminal hostile acts targeting our U.S. air carriers, airports, passengers, crew, or other transportation modes. Currently, the FAMs are required to take a mixed basic police training program and a FAMs-specific course at the Federal Law Enforcement Training Center, known as FLETC. Restoring the criminal investigative training will provide FAMs with the additional knowledge and skills required to resolve situations on the ground as well as respond to situations in-flight.

The additional training—it is 12 weeks long—includes law enforcement interview, interrogation, and behavioral assessment skills and techniques. It will, undoubtedly, provide our Federal air marshals with improved law enforcement skills not only to fly missions, but to perform the enhanced roles with our visual intermodal protection teams (VIPR) that is our VIPR teams—and other ground-based law enforcement. It therefore enhances the FAMs’ layer of security.

Detection is the principle tool utilized by our swift response teams to disrupt terrorist operations, and these investigative techniques are not currently taught to our Federal air marshals. It also provides the Department of Homeland Security Secretary and the TSA administrator a highly trained, agile, and motivated workforce capable of meeting the security challenges facing not only our transportation sector, but also the homeland itself.

Now, Mr. Speaker, our Federal air marshals have expressed a strong desire for advancement. Restoring the criminal investigative training to the Federal Air Marshal Service would also improve morale tremendously. These trained individuals who seek to be recognized as essential members of our overall law enforcement communities. This will give them the kind of training that will assist them not only in their job, but should they pursue other lines of employment in the world of law enforcement. This will provide them with the background which will assist in that.

The Federal Air Marshal Service supports the restoration of criminal investigative training to their membership. The Federal Law Enforcement Officers Association supports the bill. However, I want to emphasize this bill does not in any way reclassify the Federal air marshals as criminal investigators, known as series 1811 employees. The bill therefore before us states expressly that nothing in the bill would be construed as reclassifying FAMs as criminal investigators. That should clear up any question of a budgetary nature with respect to this bill.

I would ask for House bipartisan support of this legislation, and I reserve the balance of my time.

Ms. JACKSON-LEE of Texas. Mr. Speaker, at this time I have no further speakers. I would inquire whether the gentleman is prepared to close.

Mr. LUNGREN. Mr. Speaker, I was prepared. I am prepared to close, as I have no further speakers. I thank the gentlelady for her support on this. I thank both sides of the aisle, both staff and members of the committee. This is a commonsense approach. It’s the kind of thing that when we work together— we have worked on together here—and I hope it will pass unanimously.

With that, I would yield back the balance of my time.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield myself such time as I may consume.

Let me first of all thank my good friend, Mr. LUNGREN, again, for his collaboration in this effort. I’d like to re-emphasize points that he has made that should be reemphasized.

One, we are gratified that we have Federal U.S. Air Marshals, and we thank them for their service. They are peace officers, as we use that terminology in Texas. They are law enforcement officers. We’re gratified for that expertise. This legislation will help them add to their portfolio in training on investigation, because there is not a single action that may occur that would require their service that does not require us to have the details and the information in order to bring individuals to justice. This is important.

Might I just add that Federal air marshals have risen to the call of duty. Federal air marshals came to New Orleans, Louisiana, during Hurricane Katrina. Federal air marshals have been called upon in time of disaster, and they have answered the call.

I think it is important to note as we stand on the floor of the House to present this legislation to enhance their training that we appreciate their service. We thank them for the sacrifice of their families as they travel internationally on behalf of the American people.

Mr. THOMPSON of Mississippi. Mr. Speaker, I rise in support of H.R. 3963, the Criminal Investigative Training Restoration Act, which has the potential of bolstering the effectiveness and morale of the Federal Air Marshal Service.

Specifically, this is a bipartisan bill adds the Federal Law Enforcement Training Center’s criminal investigative training program to the basic training required for Federal Air Marshals.

H.R. 3963 directs the Federal Air Marshal Service to provide criminal investigative training to all newly hired FAMs within 30 days of enactment.

The bill creates a three-year window for all current FAMs to be provided this additional training.

This training was provide to FAMs prior to 2001 but was halted to allow the Federal Air Marshal Service to swiftly ramp up its workforce in response to the September 11th terrorist attacks.

Unfortunately, in the eight years since 9/11, the Transportation Security Administration has not moved forward to restore this training. We have heard that there were some concerns that there was a risk that FAMs, by virtue of this training, would not move forward to restore this training.

I want to emphasize this bill does not in any way reclassify the Federal air marshals as criminal investigators, known as series 1811 employees. The bill therefore before us states expressly that nothing in the bill would be construed as reclassifying FAMs as criminal investigators. That should clear up any question of a budgetary nature with respect to this bill.

I would ask for House bipartisan support of this legislation, and I reserve the balance of my time.

Mr. Speaker, at this time I have no further speakers. I would inquire whether the gentleman is prepared to close.

Mr. DANIEL E. LUNGREN of California. Mr. Speaker, at this time I have no further speakers. I thank the gentlelady for her gracious comments and her support of this bill. I rise in support of H.R. 3963, the Criminal Investigative Training Restoration Act, which has the potential of bolstering the effectiveness and morale of the Federal Air Marshal Service.

Specifically, this is a bipartisan bill adds the Federal Law Enforcement Training Center’s criminal investigative training program to the basic training required for Federal Air Marshals.

H.R. 3963 directs the Federal Air Marshal Service to provide criminal investigative training to all newly hired FAMs within 30 days of enactment.

The bill creates a three-year window for all current FAMs to be provided this additional training.

This training was provide to FAMs prior to 2001 but was halted to allow the Federal Air Marshal Service to swiftly ramp up its workforce in response to the September 11th terrorist attacks.

Unfortunately, in the eight years since 9/11, the Transportation Security Administration has not moved forward to restore this training. We have heard that there were some concerns that there was a risk that FAMs, by virtue of this training, would be reclassified as “criminal investigators.”

The legislation addresses this concern head-on by clearly stating that this such a reclassification will not occur, thereby also ensuring that the pay FAMs receive is not adversely affected.

I thank the gentleman from California, Mr. LUNGREN, for introducing this legislation and working of my colleagues to include this important provision.
I urge passage of this bipartisan bill. 

Ms. JACKSON-LEE of Texas. I would ask my colleagues to support this very important bill, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Texas (Ms. JACKSON-LEE) that the House suspend the rules and pass the bill, H.R. 3963.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

☐ 1345

EXTENDING CONDOLENCES TO FAMILIES OF SLAIN WASHINGTON OFFICERS

Mr. COHEN. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 939) extending condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards.

The Clerk reads the title of the resolution:

The text of the resolution is as follows:

H. RES. 939

Whereas, on the morning of November 29, 2009, 4 members of the Lakewood Police Department were slain by gunfire in a senseless act of violence while preparing for their shift in Lakewood, Washington;

Whereas the 4 officers have been members of the Lakewood Police Department since its founding 5 years ago, were valuable members of the community, and were deeply respected for their service;

Whereas Sergeant Mark Renninger who served 13 years in law enforcement, first with the Tukwila Police Department and most recently, served with the Lakewood Police Department, is survived by his wife and 3 children;

Whereas Officer Tina Griswold who served 14 years in law enforcement, first with the Lacey Police Department and most recently, served with the Lakewood Police Department, is survived by her husband and 2 children;

Whereas Officer Ronald Owens who served 12 years in law enforcement, first with the Washington State Patrol and most recently, served with the Lakewood Police Department, is survived by his daughter;

Whereas Officer Greg Richards who served 8 years in law enforcement, first with the Kent Police Department and most recently, served with the Lakewood Police Department, is survived by his wife and 3 children;

Whereas the senseless violence against and murder of law enforcement officers, who are sworn to serve, protect, and preserve the peace of the communities, is a particularly heinous crime; and

Whereas in the face of this senseless tragedy, the people of the City of Lakewood, the surrounding communities, and the State of Washington have come together in support of the law enforcement community and the victims; therefore, be it

Resolved, That the House of Representatives—

(1) extends its condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards; and

(2) stands with the people of Lakewood, Washington, the men and women of the Lakewood Police Department, and members of the law enforcement community as they celebrate the lives and mourn the loss of these four dedicated public servants and law enforcement heroes.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Tennessee (Mr. COHEN) and the gentleman from Oregon (Mr. POE) each will control 20 minutes.

The Chair recognizes the gentleman from Tennessee.

GENRAL LEAVE

Mr. COHEN. I ask unanimous consent that all Members may have 5 legislativa days to revise and extend their remarks and include extraneous matter on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Tennessee?

There was no objection.

This resolution extends condolences to the families of four Lakewood, Washington, police officers, Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards, who were senselessly slain by gunfire in the line of duty on Sunday, November 29, 2009. These brave and honorable Lakewood Police Department officers were ambushed as they sat in a local coffee shop, catching up on paperwork at the beginning of their Sunday morning shift.

By way of this resolution, the House of Representatives honors the lives and mourns the loss of these Lakewood police officers. We join the city of Lakewood and the entireState of Washington in celebrating the lives and grieving the deaths of these police officers.

Sergeant Mark Renninger was described as a “touching (w)ho excelled at his job and was regarded as a leader and teacher in the close-knit Lakewood police force. He was married with three children.

Officer Tina Griswold liked to cook, ride her dirt bike, and was a certified diver. Her father is a retired police officer. She began working in law enforcement as a dispatcher and came to Lakewood 5 years ago as an officer. She leaves behind a 21-year-old daughter and a 7-year-old son.

Officer Ronald Owens, known to friends and family as Ronnie, was described as having a fun-loving personality and as someone who made everyone around him feel positive. Officer Owens leaves behind a daughter.

Officer Greg Richards enjoyed music in his spare time, playing drums in a rock band. He liked nothing better than spending time with his wife, Kelly, and his three children.

By passing this resolution, we want the families of these police officers to know that they are not alone in mourning the loss of the Lakewood officers. My first job, Mr. Speaker, was as an attorney for the police department. I served 3½ years as an attorney for the Memphis Police Department, and I relate to the loss that the department and this Nation have suffered.

I urge all my colleagues to support this important resolution.

I reserve the balance of my time.

Mr. POE of Texas. Mr. Speaker, I yield myself such time as I may consume.

First of all, I want to thank the gentleman from Washington (Mr. SMITH) for sponsoring this important legislation, and I rise in support of House Resolution 939. This resolution extends our condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards. These four police officers were members of the Lakewood, Washington, police department and were ambushed by gunfire in a murderous act of violence on November 29, 2009.

These four officers were in uniform and sitting at a table in a coffee shop near their patrol area. They were preparing for their upcoming shift when a gunman with an extensive criminal record who was out on bond for another criminal offense entered the location and suddenly fired gunshots at these officers. Two of the officers were killed immediately, another was shot when he stood up from the table, and the fourth was shot after struggling with the gunman in attempting to prevent his escape. The gunman fled but not before one of the wounded dying officers had shot him.

The gunman was found 2 days later in Seattle after he challenged yet another police officer who approached him. That police officer was a 7-year veteran of the Seattle police force who noticed a parked, stolen car that was running but unoccupied. The officer approached the suspect outside the car and asked him to show his hands, but the suspect refused and started to run around the car. The officer shot and killed the suspect to prevent his escape. The officer had recognized the suspect from photographs and identified him as the main suspect in the murders of these other officers. The gunman was carrying a service weapon taken from one of the slain officers that he had murdered.

Unfortunately, police officers and law enforcement officials sometimes go unnoticed and unappreciated by communities that they protect. So far in 2010, American police officers have lost their lives in the line of duty, protecting the rest of us. These noble men and women deserve respect and gratitude from our entire Nation. Peace officers, like Sergeant Renninger, Officer Griswold, Officer Owens, and Officer Richards perform their jobs every day with the knowledge that there is a possibility that they may give their lives in service to the communities that they protect. That’s an awesome sacrifice.

As a Nation, we are grateful to peace officers who readily accept such a tremendous burden and to their families...
who accept that burden as well. In the wake of this vicious tragedy, we come together in support of the law enforcement community and the families of these individuals.

Sergeant Renninger was a 13-year law enforcement veteran, and he is survived by his wife and three children. Officer Griswold, a 14-year police veteran, is survived by her husband, a former deputy sheriff, and two children. Officer Owens, a 12-year veteran, is survived by his daughter. Officer Richards, a 9-year police veteran, is survived by his wife and three children.

The four officers were original members of the Lakewood Police Department, which was founded just 5 years ago. They are the first officers from this department to be killed in the line of duty. As the resolution so aptly states, Members of Congress stand with the people of Lakewood, Washington, the men and women of the Lakewood Police Department, and members of the law enforcement community as they honor the lives and mourn the loss of these four dedicated public servants and law enforcement heroes.

I urge my colleagues to support this resolution.

... conclude my remarks and yield the balance of my time.
the uniform at home to protect us from domestic criminals and those who wear the uniform overseas to protect us from international criminals.

Peace officers, Mr. Speaker, are the last strand of wire in the fence between the people and the lawless. Every day they put on their uniform and they put above their heart on their chest a badge, which is really a shield, a shield that’s symbolic of protecting the community from the evildoers. It goes back centuries ago. And yet they wear that shield to protect us from people who wish to do us harm. And when individuals make the decision to harm those that protect us, it is an American tragedy, and the whole country mourns with the families who have lost a police officer.

So I urge that we mourn the loss of these officers, that we honor their lives and their bravery, and that we pass this resolution immediately.

Mr. Speaker, I yield back the balance of my time.

Mr. COHEN. Mr. Speaker, I join with my friend from Texas in urging that we pass this resolution and that we do mourn these brave officers who lost their lives and stand with the people of Lakewood, Washington.

But I would also ask us to think about what happened, why these people lost their lives. And we may never know, but we do know that the person who killed them should have been behind bars. He was a criminal who was released from prison in Arkansas through executive clemency. And while there are certainly people who committed victimless crimes who are unnecessarily kept for long periods of times in incarceration and should have clemency or some type of executive relief, people who commit crimes of violence, as this person did, they should not be released unless there are some extra circumstances that are beyond anybody’s thought that it was appropriate.

This gentleman was not reformed. He committed other crimes. He still should have been in jail.

And you’ve got to think about mental health. The man was a criminal, but he was also mentally ill. He had delusions that he was some type of religious figure. And we’ve got to think about the mental health laws that we have up here and the opportunity to fund our institutions and to get mental health so that people can be treated before they commit some act out of a delusional aspect of their disease.

So there are a lot of other areas we need to be looked at as we mourn these officers and remember 9/11 and the fire officers and remember 9/11 and the fire officers and remember 9/11 and the fire officers.

Law enforcement officers are on the front lines of protecting our communities, and we must ensure they are protected, too. As a former police officer, I know, but we do know that the persons whose lives were needlessly cut short this past week in Washington State, all four officers were members of the Lakewood Police and were slain while preparing for their shift by Maurice Clemens, a career criminal who had been paroled from prison earlier this decade and was later killed by a Seattle police officer after a long manhunt.

And we stand with all the police officers in Washington State who despite losing four of their own served with distinction and bravery to bring this killer to justice.

I have long maintained that our first responders are the first line in our country’s national defense. They are on the streets every day keeping our communities and our children safe from harm.

This resolution describes violence against law enforcement officers as “particularly heinous,” which I think is an understatement. While this kind of violence against these brave community servants is not only heinous, it’s unimaginable, horrific, and unacceptable. The Federal Government must do more to protect our police officers from these kinds of violent and malicious criminals.

Congress must look at the ways we can strengthen the penalties for these kinds of horrific crimes committed against our heroes.

Our police officers are out there every day sticking their necks out for us, and we owe it to them to do everything in our power to protect them as well.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. CUELLAR). The question is on the motion offered by the gentleman from Tennessee (Mr. COHEN) that the House suspend the rules and agree to the resolution, H. Res. 939.

The question was taken; and (two-thirds being in the affirmative) the motion to suspend the rules was agreed to.

The Clerk read the text of the bill.

The text of the bill is as follows:

H.R. 515

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 “Radioactive Import Deterrence Act”.

SECTION 2. PROHIBITION OF IMPORTATION.

(a) AMENDMENT.—Chapter 19 of the Atomic Energy Act of 1944 (42 U.S.C. 2021 et seq.) is amended by inserting after section 276 the following new section:

“SEC. 277. IMPORTATION OF LOW-LEVEL RADIOACTIVE WASTE.—

“a. Except as provided in subsection b, c., the Commission shall not issue a license authorizing the importation into the United States of—

“(1) low-level radioactive waste (as defined in section 2 of the Low-Level Radioactive Waste Policy Act (42 U.S.C. 2211b)); or

“(2) specific radioactive waste streams exempted from regulation by the Commission under section 10 of the Low-Level Radioactive Waste Policy Act (42 U.S.C. 2211).

“b. Subsection a. shall not apply to—

“(1) low-level radioactive waste being returned to a United States Government or military facility which is authorized to possess the material; or

“(2) low-level radioactive waste resulting from the use in a foreign country of nuclear material obtained by the foreign user from an entity in the United States that is being returned to the United States for management and disposal.

“c. The President may waive the prohibition under this section and authorize the grant of a specific license to import materials prohibited under subsection a., under the rules of the Commission, only after a finding that such importation would meet an important national or international policy goal, such as the use of waste for research purposes. Such a waiver must specify the policy goal to be achieved, how it is to be achieved, and the amount of material to be imported.

“d. A license not permitted under this section that was issued before the date of enactment of this section may continue in effect according to its terms, but may not be extended or amended with respect to the amount of material permitted to be imported.”.

(b) TABLE OF CONTENTS AMENDMENT.—The table of contents for the Atomic Energy Act of 1944 is amended by inserting after the item relating to section 276 the following new item:

“Sec. 277. Importation of low-level radioactive waste.’’.
days in which to revise and extend their remarks and include extraneous material in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Tennessee? There was no objection.

Mr. GORDON of Tennessee. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the Radioactive Import Deterrence Act is a bipartisan bill that would ban the importation of low-level radioactive waste unless the President provides a waiver.

Low-level radioactive waste is generated by medical facilities, university research facilities, and utility companies. This waste is generated all over the United States, but finding permanent disposal sites has proven difficult. Currently, 36 States and the District of Columbia have only one approved site to store all the waste generated by those industries. That site is located in Utah. The site stores 99 percent of the United States’ low-level radioactive waste.

However, the Nuclear Regulatory Commission is currently considering the importation of some 20,000 tons of Italian low-level waste to be permanently disposed of at the Utah site. This would be the largest importation of foreign waste ever.

The United States stands alone as the only country in the world that imports other countries’ radioactive waste for permanent disposal. Other countries are reading the signs that the U.S. is poised to become a nuclear dumping ground. Permit applications are also pending for the importation of Brazilian and Mexican waste.

Foreign waste threatens the capacity that we have set aside in this country for the waste generated by our domestic industries. It is critical that Congress protect that capacity by prohibiting these imports.

I support nuclear power as part of our energy mix. 104 commercial nuclear plants in the United States help to provide 20 percent of our Nation’s electricity. I also want to support the continued growth of our domestic nuclear industry, but we must ban the practice of disposing of other countries’ radioactive waste. We must reserve that capacity for our domestic needs.

The bill is the product of a bipartisan cooperation and has received multiple hearings by both the Energy and Commerce Committee. I urge my colleagues to stand firm against the importation of foreign radioactive waste and support this bipartisan bill.

To expedite this legislation for floor consideration, the Committee on Ways and Means will forgo action on this bill. This is being done with the understanding that the Committee on Energy and Commerce will confirm in the legislative history of the bill that the President’s discretion to waive section 277(a) of the Atomic Energy Act of 1946 applies only to international or international policy goal, and is not limited to the use of waste for research purposes.

I would appreciate your response to this letter, confirming this understanding with respect to H.R. 515, and would ask that a copy of our exchange of letters on this matter be included in the Congressional Record during consideration of this bill.

Once again, thank you for your work and cooperation on this legislation.

Sincerely,

HENRY WAXMAN,
Chairman.
So I do not believe that the importation of limited amounts of common, very low-level waste raises disposal capacity issues. The GAO didn’t think so either. At the same time, I do not believe that if U.S. nuclear companies are to participate in the global nuclear services market and compete effectively with foreign-owned companies, they must simply be able to manage and dispose of the low-level waste incident to their work and subject to NRC’s regulations and requirements. So think about that. We already have in place through the NRC the necessary regulations and requirements. This is going to overlap on that.

So, Mr. Speaker. I’d like to create jobs. We cannot pass new trade barriers that put our own employers and workers at a competitive disadvantage, which I think simply this bill would do.

With that, I reserve the balance of my time.

Mr. GORDON of Tennessee. Mr. Speaker, I yield such time as he may consume to my friend from Utah (Mr. MATHESON), the coauthor of this bipartisan bill.

Mr. MATHESON. I thank Mr. GORDON for yielding.

Before I begin my comments, I have a copy of a resolution that was passed by the Salt Lake County Council in support of the Writ Act to include in the RECORD.

A RESOLUTION OF THE SALT LAKE COUNTY COUNCIL OPPOSING THE IMPORTATION OF FOREIGN NUCLEAR/RADIOACTIVE WASTE AND ITS DISPOSAL IN THE UNITED STATES

Whereas, the Nuclear Regulatory Commission (NRC) has been asked for a license to import radioactive waste from dismantled nuclear reactors in Italy; and

Whereas, Italy currently stores its nuclear/radioactive waste at power plants and other sites throughout Italy, has no permanent repository for this waste, has four closed nuclear power stations and other nuclear facilities with nuclear/radioactive waste, and for the past number of years has been caught in a waste disposal faci- lity due to strong citizen opposition; and

Whereas, due to having closed facilities and citizen opposition to construction of any new ones, reportedly have a nuclear waste disposal plan and is seeking assistance from other countries to manage different types of nuclear waste; and

Whereas, if allowed, foreign radioactive nuclear waste would be transported and

Whereas, if granted by the NRC, the importation license would allow almost ten times more waste to be imported for disposal than the total amount authorized by prior NRC importation licenses.

Now, Therefore, the County Council hereby resolves that it urges Utah’s legislative delegation to support the Radioactive Determination Act (RDR), HR 515 and S. 232, which would prohibit the importation of foreign nuclear/radioactive waste and alter the health and safety risks of transporting such materials through Salt Lake County;

Now, Therefore, the County Council hereby resolves that it supports the prohibition on the transportation of foreign generated nuclear/radioactive waste through Salt Lake County;

Now, Therefore, the County Council further resolves that it urges the NRC to not approve the request to import and dispose of foreign low-level nuclear/radioactive waste; and

Now, Therefore, the County Council further resolves that it urges the NRC to move foreign nuclear/radioactive waste from foreign countries to Utah.

Whereas, Speaker, the Energy and Commerce Committee has held two hearings on this issue: one in the previous Congress and one in this Congress. And during those hearings, we really flushed out this issue in a way that I think makes pretty clear points that justify moving this bill.

First of all, what was established is that there is confusion about what U.S. policy is relative to importation of radioactive waste from foreign countries. There really is a gap in policy here because, as our low-level radioactive waste has developed over the last two or three decades, foreign waste wasn’t even really considered. It just wasn’t conceived that we would even take waste from other countries.

As Mr. GORDON indicated, no other country in the world takes another country’s radioactive waste, and I think that appears to have been the assumption in terms of when policies have been determined in this country.

But what has happened in the last few years is that there are efforts and contracts being signed to move waste from Italy; there is discussion about Mexico, Central America to move low-level radioactive waste to this country. The Nuclear Regulatory Commission says we have no authority to determine whether or not waste from foreign countries should be allowed into this country.

So then we turn to the next regulatory body that we have in this country, and that is the system of State-run compacts that was established in Federal law primarily in 1959 to 1960. And the nuclear waste compacts are the ones who also have this role in deciding how to handle low-level radioactive waste.

The State of Utah happens to be a member of the Northwest Compact. When this proposal to move waste from Italy was put before the Compact, the Compact, with the State of Utah opposing the importation of this waste, the Compact agreed with the State of Utah need to disallow this shipment. At this point, the matter was taken to the courts. The Federal district courts have ruled the Compact courts have no authority to stop this either. That case is currently on appeal.

What this points out—and the reason I walk through these steps—is to illustrate that there’s a lot of confusion out there and everyone is pointing in a different direction of who’s in charge for this issue. And this issue ought to be addressed by Congress. It’s up from a public policy perspective to discuss whether or not as a policy of this country we should accept another country’s radioactive waste. I happen to think we shouldn’t.

No other country in the world does. I don’t think we should either. There has been mention that this is a restraint of trade issue in preventing U.S. companies from competing. I don’t know of any other country that takes imported waste.

For trade to exist, you have goods and services going in both directions, not just in one. I don’t understand how this in any way could be described as a restraint of trade.

Secondly, the capacity of this country for handling low-level waste is an issue because from what I have heard, not many States want to have a nuclear waste site for low-level waste. Even though you have heard descriptions that this low-level waste may be no more dangerous than what’s in a smoke detector. When you talk about tons and tons of this low-level radioactive waste, not a lot of States are lining up to take it.

And as we move forward as a country in a climate-constrained world where I believe—and I support development of nuclear power plants which, in addition to high-level fuel rods, do generate low-level waste—we need to have a location in this country to dispose of that low-level waste.
When the GAO did analyze the site in Utah to discuss the capacity issue, as was pointed out during the Congressional hearings before the Energy and Commerce Committee, it was pointed out that the GAO only looked at 1 year's worth of data for how much waste was put in, and they just took that volume from that year and projected it out into the future, which I'm a little disappointed that GAO would make such an elementary mistake in terms of how you project a trend, because the 1 year they used, in terms of the volume that was deposited that year, was a particularly low year in terms of volume of waste.

And in fact, even with that assumption, they projected that it would go out maybe somewhere between 20 and 30 years. That is not necessarily a long amount of time when you talk about storage of low-level waste in this country. That is not a long amount of time when you look at the issue that most States don’t want one of these sites located in their State. And I would submit that if you take the longer view of the life cycle of a nuclear power plant, that 20 to 30 years is not an excessively long amount of time, that’s the storage capacity we’ve got at this site.

By the way, the GAO report also did not assume any foreign radioactive waste would be going in the site when it made its analysis of what the capacity was.

So I think this is a good bill. I think this addresses a gap in policy today. I think it will create greater certainty for the future of the nuclear industry in this country. I think it aligns the United States with the rest of the world in how we deal with importation of radioactive waste.

I want to thank Mr. GORDON for his leadership on this issue. I encourage my colleagues to support the bill. Mr. STEARNS. Mr. Speaker, I ask how much time I have left.

The SPEAKER pro tempore. Sixteen minutes.

Mr. STEARNS. Mr. Speaker, I yield myself as much time as I may consume.

I think if you try to look at this issue in a broad sense, around the world a lot of countries are actually building nuclear power plants and there’s also countries that are decommissioning them. There are currently 436 nuclear reactors worldwide with 53 under construction. China currently has 16 reactors under construction. So this renaissance is occurring. It’s global.

So I think if you’re going to have companies that are involved with the construction and decommissioning of nuclear plants and they want to say, Okay, I want to bid, these countries will accept the bid from the United States; but if the United States is limiting them in how they’re getting rid of low level radioactive waste, it’s going to make it more difficult for that company to compete.

Again, this is not a serious problem. As far as I know, there has not been any indirect harm to individuals because of this. I obviously view this bill—the authors have crafted as a safety measure, and I respect that. But low level radioactive waste, as I mentioned, is in smoke detectors as well as exit signs.

So the implementation of this bill is going to be more regulatory, and the Nuclear Regulatory Commission is already doing this. So why would we need this bill?

And I think, as pointed out earlier in my statement, we have so many other Class B and Class C waste capacity problems that we should really be concentrating on and not this form of class, which is a very low radioactive class.

So I think, Mr. Speaker, that this is not a serious problem. I respect the authors and what they are trying to do; but, I think there’s not a need for this kind of regulatory overlay with the Nuclear Regulatory Commission, which has already done a wonderful job for decades.

So with that, Mr. Speaker, I would urge my colleagues not to support and vote “no” on the bill, and I reserve the balance of my time.

Mr. GORDON of Tennessee. Mr. Speaker, I yield myself such time as I may consume.

I have to say that my friend from Florida is making a valiant effort. I just want to talk to you about a couple of things.

First of all, Shakespeare also says “don’t smoke a dope me.” This is not B and C material. We’re talking about a material.

We’re both pro-nuclear. We would like to see additional nuclear power help us deal with our climate change, but he says this is not a serious problem. Well, it’s a very serious problem if you are a lab, if you are a hospital, if you are a utility and you have no place to take your low-level radioactive waste.

For 37 States, there is no place else to go but Utah. And when that runs out, it is out. And so that is a very serious problem.

He says it is going to hurt business. It is not going to hurt business. There is a finite amount of space there. Either you put in American waste or foreign waste; it is the same amount. So there is no business going to be hurt there.

And finally, “don’t worry about it, it is a smoke detector.” Well, if it is only smoke detectors, why are we putting up barbed wire fence, why do we have guards, and why does it have to stay there permanently? It is much more than that. There are serious problems here. This is a matter of American competitiveness. For that reason, I think that this bipartisan bill does need to pass.

I reserve the balance of my time.

Mr. STEARNS. Mr. Speaker, I reserve the balance of my time because I think the gentleman from Tennessee has additional speakers.

Mr. GORDON of Tennessee. Mr. Speaker, I regret that my friend from Florida has no one here to defend him today, and I yield such time as he may consume to Mr. CHAFFETZ, another person who this will directly impact in Utah.

Mr. CHAFFETZ. Mr. Speaker, I appreciate the work Mr. GORDON has done on this bill with broad, bipartisan support, and I appreciate the leadership of JIM MATHESON, who has led out on this issue for years.

In short, for those of you who are supportive of the nuclear industry, and like me want to see the expansion of the nuclear industry, we need to make sure that we reserve the capacity so we can deal with the waste. We won’t be able to have expansion unless we have the capacity to actually store the waste.

And for those of you who don’t want to see any sort of expansion of the nuclear industry, then why in the world would you ever want to take highly radioactive waste from foreign countries?

I am a very strong supporter of nuclear power. Currently, nuclear reactors in America provide the United States with roughly 20 percent of its electricity, yet we have built no new reactors since 1978. That is why I am a cosponsor of the American Energy Act, which establishes the national goal of bringing 100 new nuclear reactors online over the next 20 years. Achieving this goal is important for our economy, our environment, and for energy independence. This is why facilities like the one located in Clive, one of the best in the Nation and really the best in the world, need to dedicate their capacities to storage of American products. Export of our nuclear capacity will be nearly impossible if we allow our storage facilities to become saturated with foreign nuclear waste.

I support this bill and oppose the importation of waste into the country based on the basic laws of supply and demand. If the government by Italian companies is so valuable, then why do businesses in Europe not step up to the plate? There is a reason why: With $31 billion on the line, there is not one place in Europe that is willing to step up and take it. It is very dangerous. The answer, I would argue, is that other European countries do not want to take the risk of importing waste into their country. It is not a risk that I want to take for the State of Utah or for my country. And I believe that by passing this bill, I am confident that market forces will find a place for the waste somewhere other than the United States, and we can continue to propel the nuclear industry forward in the United States of America.

Mr. STEARNS. Mr. Speaker, I yield myself such time as I may consume.

I noticed that the advocates for the opponent all have these people from...
Mr. GORDON of Tennessee. I yield to the gentleman from Florida.

Mr. STEARNS. I would consider that proposal. Will you withdraw this bill? Mr. GORDON of Tennessee. Once you get it sited, then this bill may not be necessary.

Mr. STEARNS. During the process we are waiting to get sited in Florida, will you just put this bill onto a back burner?

Mr. GORDON of Tennessee. I don't think that would be the responsible thing to do for our country.

And for that reason, I yield to the gentleman from Utah (Mr. MATHESON) to clarify one of the earlier statements. Mr. MATHESON. Mr. Speaker, I just wanted to clarify one comment made by the gentleman from Florida about capacity in Utah.

It is interesting the company is telling people that they have so much capacity. They made a commitment to our Governor that they were not going to ask for an increase in the license capacity that exists today. So I am not sure if they are talking out of both sides of their mouth now, if they are telling the other side that they have plenty of capacity, but I would just put it on the record that that company is on record that they said they would not make a license request to increase the capacity at the site.

Mr. GORDON of Tennessee. If the gentleman would stay there, reclaiming my time, the Northwest Compact, did they volunteer to take this radioactive waste?

Mr. MATHESON. The imported waste?

Mr. GORDON of Tennessee. Yes.

Mr. MATHESON. The Northwest Compact, as I made some reference to in my earlier statement, voted against taking this waste.

Mr. GORDON of Tennessee. And what was the Governor's position?

Mr. MATHESON. The Governor of Utah was opposed to it. The State of Utah was opposed to it. Mr. GORDON of Tennessee. What action did the company then take?

Mr. MATHESON. The company then took the State and the Northwest Compact to court.

Mr. GORDON of Tennessee. They sued them? You mean they sued them to make them take this?

Mr. MATHESON. They took this action to Federal court because they disagreed with the decision of the State of Utah and the Northwest Compact.

Mr. GORDON of Tennessee. I'm shocked. I reserve the balance of my time.

Mr. STEARNS. Mr. Speaker, I yield myself 1 minute to attempt to reply to my colleagues.

As I understand it, this appeal process went through, and it is still in court, and so the final judgment has not been made. I think the gentleman from Utah sort of illustrates what I think is true: the company says they have the capacity to handle this.

But the overall position, I think, of many of us is that this legislation is going to hurt U.S. companies who are trying to compete with other global nuclear services in the marketplace. And as I pointed out, this is a global and highly technical and competitive industry, and it is growing, and we should not handicap companies who wish to compete in it.

Class A radioactive waste is very minimal. We have been able to take care of it. For decades and decades, the Nuclear Regulatory Commission has been able to take care of it. They have been dealing with this material, and it is not a problem for the long term or short term.

I have no further speakers, and I yield back the balance of my time.

Mr. GORDON of Tennessee. Mr. Speaker, I yield myself the balance of my time.

I say to my friend from Florida, I am not sure how much water this cup will hold, but when it is full, it is full. Now I am not sure how much, and we can talk about how much radioactive material that the Utah site can hold, but when it is full, it is full, and there will be no more space left. We need to recognize that.

In conclusion, let me just say this is very simple. Quite simply, there is only one Nation in the world that allows other countries to ship their radioactive waste to that country for permanent disposal, and that is the United States. Quite frankly, it was a loophole because it was never expected that that would happen. So what we are doing with this legislation is simply bringing it into compliance with the rest of the world, saying that our country will not accept radioactive waste, and there are 20,000 tons ready to come in, as well as other countries asking to bring that waste in.

We are simply saying we are going to abide by what all the others countries do, and they say if you have radioactive waste, if you are going to process radioactive waste, you need to take care of it, just like every other country. I think that is fair. I think it is reasonable.

Mr. STEARNS. Would the gentleman yield?

Mr. GORDON of Tennessee. I yield to my friend from Florida.

Mr. STEARNS. I thank the gentleman.

To you folks, when you hold up that glass, there is another glass in Texas that is sitting out there that you need to take care of it, just like every other country. I think that is fair. I think it is reasonable.
Mr. GORDON of Tennessee. Reclaiming my time, and I will yield right back to you, has that site been certified?

Mr. STEARNS. I think it is in the process of being certified. And there are other States that are willing to do the same thing. The importation and disposal of foreign nuclear waste is not in the interest of the country does, and for good reason! Why should the United States take Italian nuclear waste if they won’t take ours? I think the answer is simple: this House will not allow the United States to be the world’s nuclear dumping ground.

H.R. 515, to prohibit the importation of low-level nuclear waste disposal sites for U.S. low-level nuclear waste. Today, we have a few sites in the country which dispose of our low-level waste. For the moment, this is adequate. However, it is extremely difficult to establish other disposal sites. It is only practical that we carefully manage our existing domestic low-level nuclear waste disposal capacity to ensure that we do not face a crisis in the future. This will be even more critical if new nuclear reactors are built in this country.

Not only would H.R. 515 preserve existing disposal sites for our own waste, but it would maintain the integrity of the Low Level Waste Compact System, and protect the States from being forced to accept foreign nuclear waste.

When Congress established the Low Level Waste Compact System, it anticipated for the compacts to handle foreign waste. We empowered the States to establish sites for common use within the various regions, and specifically allowed them to exclude waste from outside those regions. This bill will responsibly fix a loophole which was never intended to exist.

If we fail to protect the Low Level Waste Compact System, what were supposed to be domestic disposal sites could be turned into global nuclear waste dumps. If that occurs, we could end up in a position where many States are unable—or unwilling—to participate in these compacts at all, leaving domestic companies with nowhere to go to dispose of their radioactive waste. That would not be a good development for the nuclear industry, or for the Nation.

This bill moved through the Energy and Commerce Committee under regular order, and received bipartisan support. It was reported favorably by the Subcommittee on Energy and the Environment to the full Committee by a voice vote, and the Energy and Commerce Committee sent the bill to this Floor by a strong vote of 34-12.

Mr. Speaker, I urge all of my colleagues to support this important legislation today.

Mr. TERRY. Mr. Speaker, I rise today in support of H.R. 515, the Radioactive Import Deterrence Act. This legislation will preserve our ability to regulate the importation of low-level radioactive waste produced in U.S. facilities such as clothing and items that are used in hospitals, research facilities, and nuclear power plants.

These low-level waste products are generated throughout the country, including Nebraska, which has two nuclear power plants and several medical facilities that generate these low-level waste materials that require processing and storage.

This legislation would bar the NRC from issuing licenses authorizing the importation of foreign low-level radioactive waste, unless waived by the President to meet national or international policy goals. It also exempts waste generated by the U.S. government or the military.

The United States is the only nation that allows imports of low-level radioactive waste from other countries. If we do not impose the ban on importation, the United States could easily become the preferred dumping ground for low-level radioactive waste from around the globe. This could be a problem since 36 states that do not have access to a waste compact—like Nebraska—have access to only one disposal site located in the State of Utah. Also, 94 out of 104 commercial nuclear plants in the United States use the same commercial facility as those 36 states to dispose of their low-level waste.

Mr. Speaker, we should not become the low-level radioactive waste disposal dump for the entire world. Other countries that are now using or developing nuclear power and have medical facilities generating this waste should build and operate their own storage facilities and not put American communities at risk for taking care of this radioactive waste.

I urge my colleagues to vote for H.R. 515.

Mr. GORDON of Tennessee. At this time, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Tennessee (Mr. GORDON) that the House suspend the rules and pass the bill, H.R. 515, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. STEARNS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair’s prior announcement, further proceedings on this motion will be postponed.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 2:45 clock and 45 minutes p.m.), the House stood in recess subject to the call of the Chair.

□ 1615

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. CUELLAR) at 4 o’clock and 15 minutes p.m.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The Speaker pro tempore. Pursuant to clause 8 of rule XX, proceedings will resume on motions to suspend the rules previously postponed.

Notes will be taken in the following order:

H. R. 515, by the yeas and nays;

H. Con. Res. 197, by the yeas and nays;
December 2, 2009

H.R. 1242, by the yeas and nays; and
H.R. 3980, by the yeas and nays.
Remaining postponed votes will be
taken later in the week.
The first electronic vote will be conducted as a 15-minute vote. Remaining
electronic votes will be conducted as 5minute votes.
f

RADIOACTIVE IMPORT
DETERRENCE ACT
The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and pass the
bill, H.R. 515, as amended, on which the
yeas and nays were ordered.
The Clerk read the title of the bill.
The SPEAKER pro tempore. The
question is on the motion offered by
the gentleman from Tennessee (Mr.
GORDON) that the House suspend the
rules and pass the bill, H.R. 515, as
amended.
The vote was taken by electronic device, and there were—yeas 309, nays
112, not voting 13, as follows:

jbell on DSKDVH8Z91PROD with HOUSE

[Roll No. 919]
YEAS—309
Abercrombie
Ackerman
Adler (NJ)
Altmire
Andrews
Arcuri
Baca
Baird
Baldwin
Bean
Becerra
Berkley
Berman
Berry
Bilbray
Bishop (GA)
Bishop (NY)
Blumenauer
Boccieri
Boozman
Boren
Boswell
Boucher
Boyd
Brady (PA)
Braley (IA)
Bright
Brown (SC)
Brown, Corrine
Buchanan
Butterfield
Buyer
Camp
Cantor
Cao
Capito
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Cohen
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crowley
Cuellar
Cummings

VerDate Nov 24 2008

Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ellison
Ellsworth
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Forbes
Fortenberry
Foster
Frank (MA)
Fudge
Gallegly
Garamendi
Garrett (NJ)
Gerlach
Giffords
Goodlatte
Gordon (TN)
Grayson
Green, Al
Green, Gene
Griffith
Grijalva
Guthrie
Gutierrez
Hall (NY)
Halvorson
Hare
Harman
Hastings (FL)
Heinrich
Heller
Herseth Sandlin
Hill
Himes
Hinchey
Hinojosa

03:17 Dec 03, 2009

H13425

CONGRESSIONAL RECORD — HOUSE

Hirono
Holden
Holt
Honda
Hoyer
Hunter
Inslee
Israel
Jackson (IL)
Jackson-Lee
(TX)
Johnson (GA)
Johnson (IL)
Johnson, E. B.
Jones
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick (MI)
Kilroy
Kind
King (NY)
Kirk
Kirkpatrick (AZ)
Kissell
Klein (FL)
Kosmas
Kratovil
Kucinich
Lance
Langevin
Larson (CT)
LaTourette
Lee (CA)
Lee (NY)
Levin
Lewis (GA)
Lipinski
LoBiondo
Loebsack
Lofgren, Zoe
Lowey
Luetkemeyer
Luján
Lummis
Lynch
Maffei
Maloney
Manzullo
Markey (CO)
Markey (MA)
Marshall
Massa
Matheson
Matsui
McCarthy (CA)
McCarthy (NY)
McCollum
McCotter

Jkt 089060

McDermott
McGovern
McIntyre
McKeon
McMahon
McNerney
Meek (FL)
Meeks (NY)
Michaud
Miller (NC)
Miller, George
Minnick
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Murphy (CT)
Murphy (NY)
Murphy, Patrick
Murtha
Nadler (NY)
Napolitano
Neal (MA)
Neugebauer
Nye
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor (AZ)
Paulsen
Payne
Perlmutter
Perriello
Peters
Peterson
Petri
Pingree (ME)
Platts
Polis (CO)

Pomeroy
Posey
Price (NC)
Putnam
Quigley
Rahall
Rangel
Reichert
Reyes
Richardson
Rodriguez
Rogers (AL)
Rogers (MI)
Rooney
Ros-Lehtinen
Ross
Rothman (NJ)
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Salazar
Sánchez, Linda
T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schauer
Schiff
Schrader
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Sherman
Shuler
Shuster
Sires
Skelton
Slaughter
Smith (NE)
Smith (NJ)

Akin
Alexander
Austria
Bachmann
Bachus
Bartlett
Barton (TX)
Biggert
Bilirakis
Blackburn
Blunt
Boehner
Bonner
Bono Mack
Boustany
Brady (TX)
Broun (GA)
Brown-Waite,
Ginny
Burgess
Burton (IN)
Calvert
Campbell
Carter
Cassidy
Coble
Coffman (CO)
Cole
Conaway
Crenshaw
Culberson
Davis (KY)
Dreier
Ehlers
Emerson
Fallin
Flake
Fleming
Foxx

Franks (AZ)
Frelinghuysen
Gingrey (GA)
Gohmert
Granger
Graves
Hall (TX)
Harper
Hastings (WA)
Hensarling
Herger
Hoekstra
Inglis
Issa
Jenkins
Johnson, Sam
Jordan (OH)
King (IA)
Kingston
Kline (MN)
Lamborn
Latham
Latta
Lewis (CA)
Linder
Lucas
Lungren, Daniel
E.
Mack
Marchant
McCaul
McClintock
McHenry
McMorris
Rodgers
Mica
Miller (FL)
Miller (MI)
Miller, Gary

Smith (WA)
Snyder
Space
Speier
Spratt
Stark
Stupak
Sutton
Tanner
Teague
Terry
Thompson (CA)
Thompson (MS)
Thompson (PA)
Tiberi
Tierney
Titus
Tonko
Towns
Tsongas
Turner
Van Hollen
Velázquez
Visclosky
Walden
Walz
Wamp
Wasserman
Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch
Wexler
Wilson (OH)
Wittman
Wolf
Woolsey
Wu
Yarmuth
Young (FL)

NAYS—112
Moran (KS)
Murphy, Tim
Myrick
Nunes
Olson
Paul
Pence
Pitts
Poe (TX)
Price (GA)
Radanovich
Rehberg
Roe (TN)
Rogers (KY)
Rohrabacher
Roskam
Royce
Ryan (WI)
Scalise
Schmidt
Schock
Sensenbrenner
Sessions
Shadegg
Shimkus
Simpson
Smith (TX)
Souder
Stearns
Sullivan
Taylor
Thornberry
Tiahrt
Upton
Westmoreland
Whitfield
Wilson (SC)

NOT VOTING—13
Aderholt
Barrett (SC)
Barrow
Bishop (UT)
Capuano

Gonzalez
Higgins
Hodes
Larsen (WA)
Melancon

Moran (VA)
Shea-Porter
Young (AK)

b 1645
Messrs. LUCAS, MILLER of Florida,
COLE, BRADY of Texas, BLUNT, SULLIVAN, KINGSTON, WILSON of South
Carolina, CRENSHAW, DREIER, Ms.
JENKINS, Ms. FALLIN, and Mrs.

PO 00000

Frm 00037

Fmt 7634

Sfmt 0634

EMERSON changed their vote from
‘‘yea’’ to ‘‘nay.’’
Messrs. CANTOR, MCCARTHY of
California, GOODLATTE, BUCHANAN,
WAMP,
and
Mrs.
HALVORSON
changed their vote from ‘‘nay’’ to
‘‘yea.’’
So (two-thirds being in the affirmative) the rules were suspended and the
bill, as amended, was passed.
The result of the vote was announced
as above recorded.
A motion to reconsider was laid on
the table.
f

TEMPORARY FORBEARANCE FOR
FAMILIES AFFECTED BY CONTAMINATED DRYWALL
The SPEAKER pro tempore. The unfinished business is the vote on the motion to suspend the rules and agree to
the concurrent resolution, H. Con. Res.
197, as amended, on which the yeas and
nays were ordered.
The Clerk read the title of the concurrent resolution.
The SPEAKER pro tempore. The
question is on the motion offered by
the gentlewoman from California (Ms.
WATERS) that the House suspend the
rules and agree to the concurrent resolution, H. Con. Res. 197, as amended.
This is a 5-minute vote.
The vote was taken by electronic device, and there were—yeas 419, nays 1,
not voting 14, as follows:
[Roll No. 920]
YEAS—419
Abercrombie
Ackerman
Adler (NJ)
Akin
Alexander
Altmire
Andrews
Arcuri
Austria
Baca
Bachmann
Bachus
Baird
Baldwin
Bartlett
Barton (TX)
Bean
Becerra
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop (GA)
Bishop (NY)
Blackburn
Blumenauer
Blunt
Boccieri
Boehner
Bonner
Bono Mack
Boozman
Boren
Boswell
Boucher
Boustany
Boyd
Brady (PA)
Brady (TX)
Braley (IA)
Bright
Broun (GA)
Brown (SC)
Brown, Corrine
Brown-Waite,
Ginny

E:\CR\FM\K02DE7.088

H02DEPT1

Buchanan
Burgess
Burton (IN)
Butterfield
Buyer
Calvert
Camp
Campbell
Cantor
Cao
Capito
Capps
Cardoza
Carnahan
Carney
Carson (IN)
Carter
Cassidy
Castle
Castor (FL)
Chaffetz
Chandler
Childers
Chu
Clarke
Clay
Cleaver
Clyburn
Coble
Coffman (CO)
Cohen
Cole
Conaway
Connolly (VA)
Conyers
Cooper
Costa
Costello
Courtney
Crenshaw
Crowley
Cuellar
Culberson
Cummings
Dahlkemper
Davis (AL)
Davis (CA)
Davis (IL)

Davis (KY)
Davis (TN)
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Donnelly (IN)
Doyle
Dreier
Driehaus
Duncan
Edwards (MD)
Edwards (TX)
Ehlers
Ellison
Ellsworth
Emerson
Engel
Eshoo
Etheridge
Fallin
Farr
Fattah
Filner
Flake
Fleming
Forbes
Fortenberry
Foster
Foxx
Frank (MA)
Franks (AZ)
Frelinghuysen
Fudge
Gallegly
Garamendi
Garrett (NJ)
Gerlach
Giffords
Gingrey (GA)
Gohmert


EMERGENCY ECONOMIC STABILIZATION ACT OF 2008 AMENDMENT

The SPEAKER pro tempore. The unanimous consent was agreed to.

The title was amended so as to read: “Concurrent resolution encouraging banks and mortgage servicers to work with families affected by contaminated drywall and to consider adjustments to payment schedules on their home mortgages that take into account the financial burdens of responding to the presence of such drywall.”

A motion to reconsider was laid on the table.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mrs. MALONEY) that the House suspend the rules and pass the bill, H.R. 1242, as amended, on which the yeas and nays were ordered.

The SPEAKER pro tempore. The vote was taken by electronic device, and there were—yeas 421, nays 0, not voting 13, as follows:

[Roll No. 921]

YEA—421

Abercrumbie
Agner
Akbar
Alderman
Aldridge (AL)
Akin
Alexander
Altman
Andreas
Arur
Austria
Baca
Bach
Baird
Balbent
Barrett (TX)
Bean
Becerra
Berkeley
Berman
Berry
Bigger
Bigley
Bihakros
Bishop (GA)
Bishop (NY)
Blackston
Blumenschu
Birn
Boccieri
Bolchini
Bonne
Caffey
Camp
Carter
Cavender
Chavez
Chesley
Chiou
Clark
Clay
Cochran
Coles
Conaway
Connolly (VA)
Conyers
Cooper
Cooper (NY)
Cooper (NY)
Davids (CA)
Davids (NY)
DeFazio
DeGrazio
DeJoy
DeLeuw
DeLong
Dent
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Donnelly (IN)
Doyle
Drew
Duncan
Dudley
Durr
Eberhardt
Ehlers
Ellsworth
Emerson
Eshoo
Etheridge
Farr
Faust
Fazio
Flake
Fleming
Forbes
Fortenberry
Foster
Fox
Frank (MA)
Franks (AZ)
Frelinghuysen
Gallagher
Garamendi
Garrett (NJ)
Garrison
Giffords
Gilger
Gingrey (GA)
Gingrey (IN)
Goodlatte
Gordon (TN)
Graves
Grayson
Green (AL)
Green (GA)
Green (IN)
Greene
Grijalva
Guerra
Guynn
Hale
Haller
Hansen
Harman
Hastings (FL)
Hastings (WA)
Heller
Hensarling
Herrero
Herseth Sandlin
Hill
Himes
Hinchey
Hinojosa
Holt
Honda
Hoyer
Hyers
Inouye
Jackson
Jackson-Lee
Jackson
Jenkins
Jackson
Johnson, Sam
Johnson, Todd
Jones
Jones
Jones
Jones
Johnson (GA)
Johnson (IL)
Johnson (PA)
Johnson, Sam
Jones
Jones
Jordan (OH)
Kagan
Kaiser
Kanjorski
Kaptur
Kearney
Keehan
Kilgore
King
King (CA)
Kingston
Kirk
Kirkpatrick (AZ)
Kissell
Kline (FL)
Kline (MN)
Kosmas
Kratovil
Kucinich
Kulik
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Kucinich
Kulik
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Kulik
Lange
Lang
Lane
Langevin
Larsen
LaTourette
Latham
LaTourette
Latta
Laxalt
Leach
Leach
Lebo
Lebowski
Ledig
Lesser
Lewis
Levin
Lewis (GA)
Linder
Lipinski
Lobiondo
Loebsack
Lowey
Lowe
Lucas
Luetkemeyer
Lummis
Longeren, Daniel
Lynch
Mack
Mansfield
Manzullo
Marrinello
Markey (CO)
Markey (MA)
Marshall
Massa
Massialas
Matos
Mayes
McCarth
McClintock
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The Speaker pro tempore (Ms. Pelosi) stated as follows:

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Ms. Pelosi) announced the following:

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H. RES. 648

Mr. WILSON of South Carolina. Madam Speaker, I ask unanimous consent to be removed as a cosponsor of H. Res. 648.

The SPEAKER pro tempore (Ms. Pelosi) announced that there is no objection to the removal of the member from South Carolina.

There was no objection.

REPORT ON RESOLUTION PROVING FOR CONSIDERATION OF H. R. 4154, PERMANENT ESTATE TAX RELIEF FOR FAMILIES, FARMERS, AND SMALL BUSINESSES ACT OF 2009

Mr. POLIS, from the Committee on Rules, submitted a privileged report (Rept. No. 111–115) on the resolution (H. Res. 911) providing for consideration of the bill (H.R. 4154) to amend the Internal Revenue Code of 1986 to repeal the new carryover basis rules in order to prevent tax increases and the imposition of compliance burdens on many more estates than would benefit from repeal, to retain the estate tax with a $5,000,000 exemption, and for other purposes, which was referred to the House Calendar and ordered to be printed.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore, pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on the motion to suspend the rules on which a recorded vote or the
years and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX.

Any record vote on the postponed question will be taken later.

SATELLITE HOME VIEWER REAUTHORIZATION ACT OF 2009

Mr. CONYERS, Madam Speaker, I move to suspend the rules and pass the bill (H.R. 3570) to amend title 17, United States Code, to reauthorize the satellite and cable statutory licenses to conform the satellite and cable statutory licenses to all-digital transmissions, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3570

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

SEC. 1. SHORT TITLE.

This Act may be cited as the “Satellite Home Viewer Reauthorization Act of 2009”.

SEC. 101. REFERENCE TO TITLE 17.

Except as otherwise provided, whenever in this title an amendment is made to a section or other provision, the reference shall be considered to be made to such section or provision of title 17, United States Code.

SEC. 102. MODIFICATIONS TO STATUTORY LICENSE FOR SATELLITE CARRIERS.

(a) HEADING RENAMED.—

(1) IN GENERAL.—The heading of section 119 is amended by striking “superstations and network stations for private home viewing” and inserting “distant television programming satellite stations”.

(2) TABLE OF CONTENTS.—The table of contents for chapter 1 is amended by striking the item relating to section 119 and inserting the following:

“119. Limitations on exclusive rights: Secondary transmissions of distant television programming by satellite carriers”.

(b) UNSERVED HOUSEHOLD DEFINED.—

Section 119(d)(10) is amended—

(1) by striking subparagraph (A) and inserting the following:

“(A) by adding the following: ”;

(2) in paragraph (1), by striking subparagraph (A) and inserting the following:

“(A) through the use of a conventional, stationary, outdoor rooftop receiving antenna, an over-the-air signal containing the primary stream, or, on or after January 1, 2013, the multicast stream, originating in that household’s local market and affiliated with that network of—

(i) if the signal originates as an analog signal, Grade B intensity as defined by the Federal Communications Commission in section 73.683(a) of title 47, Code of Federal Regulations, as in effect on January 1, 1999; or

(ii) if the signal originates as a digital signal, intensity defined in the values for digital television noise-limited service contour, as defined in regulations issued by the Federal Communications Commission (section 73.622(e) of title 47, Code of Federal Regulations), as such regulations may be amended from time to time”;

(3) in subparagraph (B)—

(A) by striking “subsection (a)(14)” and inserting “subsection (a)(13)”;

(B) by striking “Satellite Home Viewer Extension Act of 2009” and inserting “Satellite Home Viewer Reauthorization Act of 2009”; and

(4) in paragraph (4), as redesignated—

(A) by striking “subsection (a)(14)” and inserting “subsection (a)(13)”;

(B) by striking “Satellite Home Viewer Extension Act of 2009” and inserting “Satellite Home Viewer Reauthorization Act of 2009”; and

(C) by striking “subsection (a)(11)” and inserting “subsection (a)(10)”;

(D) by striking “Section 119(b)(1)” and inserting “Section 119(b)”; and

(E) by striking “(a)(11)” and inserting “(a)(10)”; and

(F) by striking “section 300101 of title 36;”.

(c) FILING FEE.—Section 119(b)(1) is amended—

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

(2) in paragraph (B), by striking the period and inserting “; and”; and

(3) by adding after paragraph (F) the following:

“(C) a filing fee, as determined by the Register of Copyrights pursuant to section 705(b).”;

(d) EMERGENCY MONITORING, PLANNING, OR RESPONDING.—Section 119(a) is amended by adding at the end the following:

“(8) NETWORKS OF NONCOMMERCIAL EDUCATIONAL BROADCAST STATIONS.—In the case of a system of three or more noncommercial educational broadcast stations licensed by a single State, public agency, or political, educational, or special purpose subdivision of a State, the statutory license provided for in subparagraph (A) shall apply to the secondary transmission of the primary transmission of such system to any subscriber in any county within such State, if such subscriber is located in a market area that is not otherwise eligible to receive the secondary transmission of the primary transmission of such system.”;

(e) LICENSE TO USE DETERMINATIONS.—Section 119(c) is amended as follows:

(1) by adding at the end the following:

“(17) REVERSE TRAFFIC.—The registrations and verification procedures described under subparagraph (A) that are made after the end of the 30-month period beginning on the effective date of the regulations issued by the Secretary of Homeland Security under subparagraph (C).”;

(2) by inserting “The term ‘traffic’ shall apply with respect to secondary transmissions described under subparagraph (A) that are made after the end of the 30-month period beginning on the effective date of the regulations issued by the Secretary of Homeland Security under subparagraph (C).”;

(f) DEPOSIT OF STATEMENTS AND FEES; VERIFICATION PROCEDURES.—Section 119(b) is amended—

(1) by amending the subsection heading to read as follows: “(b) DEPOSIT OF STATEMENTS AND FEES; VERIFICATION PROCEDURES.”;

(2) in paragraph (1), by striking subparagraph (A) and inserting the following:

“A royalty fee payable to copyright owners pursuant to paragraph (4) for that 6-month period, computed by multiplying the total number of subscribers receiving each secondary transmission of a primary or multicast stream of each non-network station or network station during each calendar year month by the appropriate rate in effect under this subsection”;

(3) by redesignating paragraphs (2), (3), and (4) as paragraphs (3), (4), and (5), respectively;

(4) by inserting after paragraph (1) the following:

“(2) VERIFICATION OF ACCOUNTS AND FEE PAYMENTS.—The Register of Copyrights shall provide to any interested party to whom a statement of accounts and royalties is submitted under paragraph (1) a means to verify and audit the statements of account and royalty fees submitted by satellite carriers under this subsection.”;

(5) in paragraph (3), as redesignated, in the first sentence—

(A) by inserting “including the filing fee specified in paragraph (1)(C)” after “shall receive all fees”; and

(B) by striking “paragraph (4)” and inserting “paragraph (5)”;

(6) in paragraph (4), as redesignated—

(A) by striking “paragraph (3)” and inserting “paragraph (5)”;

(B) by striking “paragraph (4)” each place it appears and inserting “paragraph (5)”;

(C) by inserting “paragraph (5)” after “paragraph (3)”;

(D) by striking paragraph (6) and inserting “paragraphs (6) and (7)”;

(E) by striking paragraph (7) and inserting “paragraphs (7) and (8)”;

(F) by striking paragraph (8) and inserting “paragraphs (8) and (9)”;

(G) by inserting “paragraph (9)” after “paragraph (8)”;

(H) by striking paragraph (9) and inserting “paragraphs (9) and (10)”;

(I) by adding at the end the following:

“(8) ADJUSTMENT OF ROYALTY FEES.—Section 119(c) is amended as follows:

(A) in the heading for such paragraph, by striking “ANALOG”;

(B) by striking “paragraph (A)” and inserting “paragraph (B)”;

(C) by striking “July 1, 2004” and inserting “July 1, 2009”; and

(D) by striking “July 1, 2004” and inserting “July 1, 2009”; and

(E) by striking “July 1, 2009” and inserting “July 1, 2004”. “(b) DEPOSIT OF STATEMENTS AND FEES; VERIFICATION PROCEDURES.—Section 119(b) is amended—

(1) by amending the subsection heading to read as follows: “(b) DEPOSIT OF STATEMENTS AND FEES; VERIFICATION PROCEDURES.”;

(2) in paragraph (1), by striking subparagraph (A) and inserting the following:

“A royalty fee payable to copyright owners pursuant to paragraph (4) for that 6-month period, computed by multiplying the total number of subscribers receiving each secondary transmission of a primary or multicast stream of each non-network station or network station during each calendar year month by the appropriate rate in effect under this subsection”;

(3) by redesignating paragraphs (2), (3), and (4) as paragraphs (3), (4), and (5), respectively;

(4) by inserting after paragraph (1) the following:

“(2) VERIFICATION OF ACCOUNTS AND FEE PAYMENTS.—The Register of Copyrights shall provide to any interested party to whom a statement of accounts and royalties is submitted under paragraph (1) a means to verify and audit the statements of account and royalty fees submitted by satellite carriers under this subsection.”;

(5) in paragraph (3), as redesignated, in the first sentence—

(A) by inserting “including the filing fee specified in paragraph (1)(C)” after “shall receive all fees”; and

(B) by striking “paragraph (4)” and inserting “paragraph (5)”;

(6) in paragraph (4), as redesignated—

(A) by striking “paragraph (3)” and inserting “paragraph (5)”;

(B) by striking “paragraph (4)” each place it appears and inserting “paragraph (5)”;

(C) by inserting “paragraph (5)” after “paragraph (3)”;

(D) by striking paragraph (6) and inserting “paragraphs (6) and (7)”;

(E) by striking paragraph (7) and inserting “paragraphs (7) and (8)”;

(F) by striking paragraph (8) and inserting “paragraphs (8) and (9)”;

(G) by inserting “paragraph (9)” after “paragraph (8)”;

(H) by striking paragraph (9) and inserting “paragraphs (9) and (10)”;

(I) by adding at the end the following:

“(8) ADJUSTMENT OF ROYALTY FEES.—Section 119(c) is amended as follows:

(A) in the heading for such paragraph, by striking “ANALOG”;

(B) by striking “paragraph (A)” and inserting “paragraph (B)”;

(C) by striking “July 1, 2004” and inserting “July 1, 2009”; and

(D) by striking “July 1, 2004” and inserting “July 1, 2009”; and

(E) by striking “July 1, 2009” and inserting “July 1, 2004”. December 2, 2009

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(i) by striking “January 2, 2005, the Librarian of Congress” and inserting “January 4, 2010, the Copyright Royalty Judges”; and
(ii) by striking “primary analog transmissions and inserting “primary transmissions”; (D) in subparagraph (C), by striking “Librarian of Congress” and inserting “Copyright Royalty Judges”; (E) in subparagraph (D)—  (i) in clause (i)— (I) by striking “(i) Voluntary agreements” and inserting “the proceeding”; “(i) VOLUNTARY AGREEMENTS; FILING.—Voluntary agreements”; and (II) by striking “that a parties and inserting “that parties”; and (ii) in clause (ii)— (I) by striking “(ii)(i) Within” and inserting “the following”:

(ii) PROCEDURE FOR ADOPTION OF FEES.— (I) PUBLICATION OF NOTICE.—Within. (II) in subclause (I), by striking “an arbitration proceeding pursuant to subparagraph (E) and inserting “a proceeding under subparagraph (F)”; and (III) in subclause (II), by striking “(II) Upon receiving a request under subclause (I), the Librarian of Congress” and inserting the following: “(II) PUBLIC NOTICE OF FEES.—Upon receiving a request under subclause (I), the Copyright Royalty Judges”; and (IV) in subclause (III)— (aa) by striking “(III) The Librarian” and inserting; “the following”:

(III) ADOPTION OF FEES.—The Copyright Royalty Judges; (bb) by striking “an arbitration proceeding” and inserting “the proceeding under subparagraph (F)”; and (cc) by striking “the proceeding” and inserting “the proceeding”.

(F) in subparagraph (E)—  (i) by striking “Copyright Office” and inserting “Copyright Royalty Judges”; and (ii) by striking “December 31, 2009” and inserting “December 31, 2014” and (G) in subparagraph (F)—  (i) in the heading, by striking “COMPULSORY ARBITRATION” and inserting “COPYRIGHT ROYALTY JUDGES PROCEEDING”;

(ii) in clause (i)— (I) in the heading, by striking “PROCEEDINGS” and inserting “THE PROCEEDING”;

(II) in the matter preceding subclause (I)— (aa) by striking “May 1, 2005, the Librarian of Congress” and inserting “May 3, 2010, the Copyright Royalty Judges”;

(bb) by striking “arbitration proceedings” and inserting “a proceeding”; (cc) by striking “the single digital stream of program—” and inserting “‘fees to be paid’”; and (dd) by striking “primary analog transmission” and inserting “the primary transmission”;

(ee) by striking “distributors” and inserting “distributors—”;

(III) in subclause (II)— (aa) by striking “the Librarian of Congress” and inserting “Copyright Royalty Judges”; and

(bb) by striking “arbitration”; and

(IV) by amending the last sentence to read as follows: “Such proceeding shall be conducted under chapter 8.”;

(iii) in clause (ii), by amending the matter preceding subparagraph (C) and inserting “charged as follows:” “(ii) ESTABLISHMENT OF ROYALTY FEES.—In determining royalty fees under this subparagraph, the Copyright Royalty Judges shall establish fee payments for the secondary transmissions of the primary transmissions of network stations and non-network stations that most clearly represent the fair market value of that transmission, including with respect to each party that the Copyright Royalty Judges shall adjust royalty fees to account for the obligations of the parties under any applicable voluntary agreement filed with the Copyright Royalty Judges in accordance with subparagraph (D). In determining the fair market value, the Judges shall consider their decision on economic, competitive, and programming information presented by the parties, including:

(iv) by amending clause (iii) to read as follows: “(III) EFFECTIVE DATE FOR DECISION OF COPYRIGHT ROYALTY JUDGES.—The obligation to pay the royalty fee referred to in subparagraph (A) shall apply to the secondary transmission by any person, entity, or entity receiving such transmission from a satellite carrier of the primary transmission, as of January 1, 2014, and

(v) in clause (iv)— (I) in the heading, by striking “FEE” and inserting; “fees”.

(II) by striking “fee” and inserting “fees.”

(2) Paragraph (2) is amended to read as follows: “(2) ANNUAL ROYALTY PER ADJUSTMENT.—Effective January 1 of each year, the royalty fee payable under subsection (b)(1)(B) for the secondary transmissions of network stations shall be adjusted by the Copyright Royalty Judges to reflect any changes occurring in the cost of living as determined by the Consumer Price Index (for all consumers and for all items) published by the Secretary of Labor before December 1 of the preceding year. Notice of the adjusted fees shall be published in the Federal Register at least 25 days before January 1.”.

(b) DEFINITIONS.—(1) SUBSCRIBER.—Section 119(d)(8) is amended to read as follows: “(8) SUBSCRIBER.—(A) ‘Subscriber’ means a person or entity that receives a secondary transmission service from a satellite carrier and pays a fee for the service, directly or indirectly, to the satellite carrier or to a distributor.

(B) ‘subscriber’ means to elect to become a subscriber.”.

(2) LOW POWER TELEVISION STATION.—Section 119(d)(12) is amended by striking “low power television as” and inserting “low power TV station as”.

(3) LOCAL MARKET.—Section 119(d)(11) is amended to read as follows: “(11) LOCAL MARKET.—The term ‘local market’ has the meaning given such term under section 122(i).”.

(4) NONCOMMERCIAL EDUCATIONAL BROADCAST STATION.—Section 119(d)(13) is amended—

(A) by striking “(b)(2)(B), by striking ‘as defined in section 397 of the Communications Act of 1934’) and

(B) by adding at the end the following:

(14) NONCOMMERCIAL EDUCATIONAL BROADCAST STATION.—The term ‘noncommercial educational broadcast station’ means a television broadcast station that—

(A) under regulations of the Federal Communications Commission in effect on November 2, 1978, is eligible to be licensed by the Federal Communications Commission as a noncommercial educational television broadcast station and is owned and operated by a public agency or nonprofit private foundation, corporation, or association; or

(B) is owned and operated by a municipality and transmits only public educational television broadcast stations”.

(5) ROYALTY FEES.—A satellite carrier whose secondary transmission of the primary transmission of the programming of a low power television station is subject to statutory licensing under this section shall be subject to royalty payments under subsection (b)(1)(B) for any transmission to a subscriber outside of the local market of the license under this section.

(D) LIMITATION TO SUBSCRIBERS TAKING LOCAL-TO-LOCAL SERVICE.—Secondary transmissions provided for in subparagraph (A) shall not be subject to royalty payments to any local television station that retransmits the programs and signals of another television station for more than 2 hours each day.

(E) ROYALTY FEES.—A satellite carrier whose secondary transmission of the primary transmission of the programming of a low power television station is subject to statutory licensing under this section shall be subject to royalty payments under subsection (b)(1)(B) for any transmission to a subscriber outside of the local market of the license under this section.

(k) REMOVAL OF SIGNIFICANTLY VIEWED PROVISION.

(1) REMOVAL OF PROVISION.—Section 119(a), as added by subsection (a), is amended—

(B) by striking paragraph (3) and redesignating paragraphs (4) through (17) as paragraphs (5) through (16), respectively.

(3) CONFORMING AMENDMENTS.—Section 119 is amended—

(A) in subsection (a)
under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) Except in the case in which clause (11) applies, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.

(11) If, at the time such person seeks to so subscribe, the satellite carrier does not offer service in the subscriber's local market pursuant to section 122, the statutory license under paragraph (2) shall apply to secondary transmissions by that satellite carrier to that subscriber of the distant signal of a station affiliated with the same television network, until such time as the subscriber elects to terminate such transmissions.
If the network station or non-network station fails to accept or reject the subscriber's request for a waiver within that 30-day period, that network station or non-network station shall be deemed to agree to the waiver request. 

"(3) SECONDARY TRANSMISSION OF LOW POWER PROGRAMMING.—(A) General—Subject to subparagraphs (B) through (D) of this paragraph, the statutory license provided under paragraph (1) shall apply to the secondary transmission by a satellite carrier of the primary transmission of a network station or a non-network station that is licensed as a low power television station if: (I) the subscriber who resides within the same local market as the station that originates the transmission; (II) the secondary transmission is not required, by the terms of a contract, to retransmit programs and signals of another television station for more than 2 hours each day; (III) the secondary transmission of programs and signals of the primary network or non-network station is permitted by the applicable broadcast license to permit retransmission of programs and signals of another television station for more than 2 hours each day; and (IV) the secondary transmission is not required, by the terms of a contract, to retransmit programs and signals of another television station for more than 2 hours each day.

"(B) No applicability to repeaters and translators.—Secondary transmissions provided for in subparagraph (A) shall not apply to any low power television station that retransmits the programs and signals of another television station for more than 2 hours each day.

"(C) LIMITATION ON SUBSCRIBERS TAKING LOCAL-INTO-LOCAL SERVICE.—Secondary transmissions of a satellite carrier provided for in subparagraph (A) may be made only to subscribers who receive secondary transmissions of primary transmissions from that satellite carrier pursuant to the statutory license provided under section 122, or pursuant to the statutory license in paragraph (1), and only in conformity with the requirements under section 340(b) of the Communications Act of 1934, as in effect on June 1, 2004.

"(D) No impact on other secondary transmissions obligations.—A satellite carrier that makes secondary transmissions of a primary transmission of a low power television station pursuant to the statutory license provided under this section is not required, by reason of such secondary transmissions, to make any other secondary transmissions.

"(e) Reporting Requirements.—Section 122(b) is amended—(1) in paragraph (1), by striking "station a list" and all that follows through the end and inserting the following: 'station—(A) a list identifying (by name in alphabetical order and street address, including county and 9-digit zip code) all subscribers to whom the contract makes secondary transmissions of that primary transmission under subsection (a); and (B) a separate list, aggregated by designated market area, which shall indicate those subscribers being served pursuant to subsection (a)(2), relating to significantly viewed stations.'; and (2) in paragraph (2), by striking "network a list" and all that follows through the end and inserting the following: 'network—(A) a list identifying (by name in alphabetical order and street address, including county and 9-digit zip code) all subscribers to whom the contract makes secondary transmissions of that primary transmission under subsection (a); and (B) a separate list, aggregated by designated market area (by name and street address, including city, State, and 9-digit zip code), which shall indicate those subscribers being served pursuant to subsection (a)(2), relating to significantly viewed stations.'; and

"(f) Additional requirements.—(1) In general.—The heading of section 111 is amended by striking the item relating to section 111 and inserting the following: "111. Limitations on exclusive rights: Secondary transmissions of broadcast programming by cable.". (2) Table of contents.—The table of contents for chapter 1 is amended by striking the item relating to section 111 and inserting the following: "111. Limitations on exclusive rights: Secondary transmissions of broadcast programming by cable.".
TRANSMISSIONS BY CABLE SYSTEMS.—Section 111(d) is amended—

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A)—

(i) by striking “A cable system whose secondary” and inserting the following: “TRANSMISSIONS OF PRIMARY AND Royalty Rates."—Subject to paragraph (5), a cable system whose secondary;” and

(ii) by striking “by regulation—” and inserting “by regulation” the following:

(B) in subparagraph (A)—

(i) by striking “a statement of account” and inserting “a statement of account”;

(ii) by striking “;” and inserting a period; and

(C) by striking subparagraphs (B), (C), and (D), and inserting the following:

(B) in paragraph (2), in the first sentence—

(i) by striking “any such” and inserting “any such”; and

(ii) by striking ‘‘A ‘cable system’ ‘catastrophic incident’.—The term ‘catastrophic incident’ means any natural disaster, act of terrorism, or other man-made disaster that results in extraordinary levels of casualties or damage or disruption severely affecting the population (including mass evacuations), infrastructure, the environment, the economy, national morale, or governmen...(continued)

(i) by striking “shall be subject to an action for infringement, or eligible for any royalty refund or offset, arising out of its use of such methodology on such statement.”

(ii) the royalty fee payable under this paragraph to copyright owners pursuant to paragraph (3) shall be 0.5 percent, regardless of the number of distant signal equivalents, if any.

(iii) if the actual gross receipts paid to subscribers to a cable system for the period covered by the statement for the basic service of providing secondary transmissions of primary broadcast transmitters are $263,800 or less—

(iv) 0.330 percent of such gross receipts for any, payable pursuant to clauses (ii) through (iv), inclusive.

(ii) 1 percent of any gross receipts in excess of $527,600, regardless of the number of distant signal equivalents, if any;

(iii) 0.701 percent of such gross receipts for the fifth distant signal equivalent and each distant signal equivalent thereafter.

(ii) the gross receipts and the distant signal equivalent values for such secondary transmission shall be derived solely on the basis of the subscribers in those communities which the station or system provides such secondary transmission; and

(ii) the royalty fee for the period paid by such system shall not be less than the royalty calculated using methodology consistent with subparagraph (C)(iii) or that amends a statement filed before such date of enactment to compute the royalty fee due using such methodology, shall be subject to an action for infringement, or eligible for any royalty refund or offset, arising out of its use of such methodology on such statement.

(i) by striking “A ‘cable system’ whose royalty fee is specified in subparagraph (E) or (F), a total royalty payable to copyright owners pursuant to subparagraph (i) by striking ‘any such’ and inserting ‘any such’; and

(ii) by striking “a statement of account” and inserting “a statement of account”;

(iii) by striking ‘‘;” and inserting a period; and

(C) by striking subparagraphs (B), (C), and (D), and inserting the following:

(B) in paragraph (2), in the first sentence—

(i) by striking “any such” and inserting “any such”; and

(ii) by striking the semicolon and inserting a period after the following:

(i) by striking “a statement of account” and inserting “a statement of account”;

(ii) by striking “;” and inserting a period;

(C) in subparagraph (B)—

(i) by striking “any such” and inserting “any such”;

(ii) by striking the semicolon and inserting a period; and

(D) in subparagraph (C), by striking “any such” and inserting “any such”;

(3) in paragraph (3)—

(A) by striking “The royalty fees” and inserting the following: “H ANDSLING OF FEES.—The Register of Copyrights pursuant to section 204, shall take effect commencing with the first accounting period occurring in 2010.

(2) in the second undesignated paragraph—

(A) by striking “A ‘secondary transmission’ is a transmission made to the public by a transmitting facility whose signals are being received and further transmitted by a secondary transmission service, regardless of where or when the performance or display was first transmitted. In the case of a television broadcast station, the primary stream and any multicast streams transmitted by the station constitute primary transmissions.”

(ii) by striking “any such” and inserting “any such”;

(iii) by striking the semicolon and inserting a period.

(3) in the third undesignated paragraph—

(A) by striking “A ‘cable system’” and inserting the following: “CABLE SYSTEM.—A ‘cable system’”; and

(B) by striking “ ‘Territory, Trust Territory, or Possession’” and inserting “ ‘Territory, Trust Territory, or Possession’”;

(4) in the fourth undesignated paragraph, in the first sentence—

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

(1) by striking “A ‘cable system’” and inserting the following: “A ‘cable system’”; and

(B) by striking “ ‘Territory, Trust Territory, or Possession’” and inserting “ ‘Territory, Trust Territory, or Possession’”;

(4) in the fourth undesignated paragraph, in the first sentence—

(6) by striking “A ‘cable system’’ and inserting the following: “‘catastrophic incident’.—The term ‘catastrophic incident’ means any natural disaster, act of terrorism, or other man-made disaster that results in extraordinary levels of casualties or damage or disruption severely affecting the population (including mass evacuations), infrastructure, the environment, the economy, national morale, or government is a...paragraph (C)(iii) or that amends a statement filed before such date of enactment to compute the royalty fee due using such methodology, shall be subject to an action for infringement, or eligible for any royalty refund or offset, arising out of its use of such methodology on such statement.”

(ii) by striking the semicolon and inserting a period after the following:

(i) by striking “any such” and inserting “any such”; and

(ii) by striking the semicolon and inserting a period.

(3) in the third undesignated paragraph—

(A) by striking “A ‘cable system’” and inserting the following: “CABLE SYSTEM.—A ‘cable system’”; and

(B) by striking “ ‘Territory, Trust Territory, or Possession’” and inserting “ ‘Territory, Trust Territory, or Possession’”;

(4) in the fourth undesignated paragraph, in the first sentence—

(6) by striking “A ‘cable system’” and inserting the following: “A ‘cable system’”; and

(B) by striking “ ‘Territory, Trust Territory, or Possession’” and inserting “ ‘Territory, Trust Territory, or Possession’”;

(4) in the fourth undesignated paragraph, in the first sentence—

(6) by striking “A ‘cable system’” and inserting the following: “A ‘cable system’”; and

(B) by striking “ ‘Territory, Trust Territory, or Possession’” and inserting “ ‘Territory, Trust Territory, or Possession’”;

(4) in the fourth undesignated paragraph, in the first sentence—

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

(1) by striking “A ‘cable system’” and inserting the following: “A ‘cable system’”; and

(B) by striking “ ‘Territory, Trust Territory, or Possession’” and inserting “ ‘Territory, Trust Territory, or Possession’”;

(4) in the fourth undesignated paragraph, in the first sentence—

(6) by striking “A ‘cable system’” and inserting the following: “A ‘cable system’”; and

(B) by striking “ ‘Territory, Trust Territory, or Possession’” and inserting “ ‘Territory, Trust Territory, or Possession’”;

(4) in the fourth undesignated paragraph, in the first sentence—
(A) by striking ‘‘The ‘local service area of a primary transmitter’’, in the case of a television broadcast station, comprises the area in which such station is entitled to insist and inserting the following:

‘‘(4) LOCAL SERVICE AREA OF A PRIMARY TRANSMITTER.—The ‘local service area of a primary transmitter’, in the case of both the primary stream of a multicast stream transmitted by a primary transmitter that is a television broadcast station, comprises the area where such primary transmitter could have been located.

(B) by striking ‘‘76.59 of title 47 of the Code of Federal Regulations’’ and inserting the following:

‘‘76.59 of title 47, Code of Federal Regulations, or within the noise-limited contour as defined in 73.622(e)(1) of title 47, Code of Federal Regulations’’; and

(C) by striking the second sentence of the rules and regulations of the Federal Communications Commission.’’;

(5) by amending the fifth undesignated paragraph to read as follows:

‘‘(5) DISTANT SIGNAL EQUIVALENT.—

‘‘(A) IN GENERAL.—Except as provided under subparagraph (B), a ‘distant signal equivalent’:

‘‘(i) is the value assigned to the secondary transmission of any non-network television programming carried by a cable system in whole or in part on the local service area of the primary transmitter of such programming;

‘‘(ii) is computed by assigning a value of one to each primary stream and to each multicast stream (other than a simulcast) that is an independent station, and by assigning a value of one-quarter to each primary stream and to each multicast stream (other than a simulcast) that is a network or noncommercial station.

‘‘(B) EXCEPTIONS.—The values for independent, network, and noncommercial educational stations specified in subparagraph (A) are subject to the following:

‘‘(i) Where the rules and regulations of the Federal Communications Commission require a cable system to omit the further transmission of a particular program and such rules and regulations also permit the substitution of another program embodying a performance or display of a work in place of the omitted program, or where such rules and regulations in effect on the date of enactment of the Copyright Act of 1976 permit a cable system to substitute such omission and substitution of a nonlive program or to carry additional programs not transmitted by primary transmitters within whose area the cable system is located, no value shall be assigned for the substituted or additional program.

‘‘(ii) Where the rules, regulations, or authorizations of the Federal Communications Commission in effect on the date of enactment of the Copyright Act of 1976 permit a cable system, at its election, to omit the further transmission of a particular program and such rules, regulations, or authorizations also permit the substitution of another program embodying a performance or display of a work in place of the omitted transmission, the value assigned for the substituted or additional program shall be, in the case of a live program, the value of one full distant signal equivalent multiplied by a fraction that has as its numerator the number of days in the year in which such substitution occurs and as its denominator the number of days in the year.

‘‘(iii) In the case of the secondary transmission of a primary transmitter that is a television broadcast station pursuant to the late-night or specialty programming rules of the Federal Communications Commission, or the secondary transmission of a primary transmitter that is a television broadcast station on a part-time basis when full-time carriage is not possible because the cable system lacks the activated channel capacity or is not required to do so by the Copyright Act of 1976, the value assigned for the secondary transmission shall be multiplied by a fraction that is equal to the ratio of the broadcast hours of such primary transmitter transmitted by the cable system to the total broadcast hours of the primary transmitter.

‘‘(iv) No value shall be assigned for the secondary transmission of the primary stream of a television broadcast station that is a network station that transmits all or substantially all of the programming of an interconnected program service.

‘‘(v) In the case of a television broadcast station that is not the station’s primary transmitter, to the extent such amendments assign a ‘distant signal equivalent value (referred to in section 111 of title 17, United States Code)’ to such existing written agreements for the secondary transmission of such streams that are made on or before June 30, 2010.

(6) by striking the sixth undesignated paragraph and inserting the following:

‘‘(6) NETWORK STATION.—

‘‘(A) TREATMENT OF PRIMARY STREAM.—The term ‘network station’ shall be applied to a primary stream of a television broadcast station that is owner or operated by, or affiliated with, one or more of the television networks that materially all of the programming of an interconnected program service that is, or that would be, otherwise provided by such networks for a substantial part of the programming supplied by such networks for a substantial part of the primary stream’s typical broadcast day.

‘‘(B) TREATMENT OF MULTICAST STREAMS.—The term ‘network station’ shall be applied to a multicast stream in which a television broadcast station transmits all or substantially all of the programming of an interconnected program service that—

‘‘(i) is owner or operated by, or affiliated with, one or more of the television networks described in subparagraph (A); and

‘‘(ii) offers programming on a regular basis for 15 or more hours per week to at least 25 of the affiliated television licensees of the interconnected program service in 10 or more States.’’;

(7) by striking the seventh undesignated paragraph and inserting the following:

‘‘(7) INDEPENDENT STATION.—The term ‘independent station’ shall be applied to the primary stream of a television broadcast station that is not a network or noncommercial educational station.

‘‘(8) NONCOMMERCIAL EDUCATIONAL STATION.—The term ‘noncommercial educational station’ shall be applied to a noncommercial educational broadcast station as defined in section 397 of the Communications Act of 1934, as in effect on the date of enactment of the Satellite Home Viewer Reauthorization Act of 2003.’’;

(8) by striking the eighth undesignated paragraph and inserting the following:

‘‘(8) NONCOMMERCIAL EDUCATIONAL STATION.—A ‘noncommercial educational station’ is a noncommercial educational broadcast station as defined in section 397 of the Communications Act of 1934, as in effect on the date of enactment of the Satellite Home Viewer Reauthorization Act of 2003.’’;

(9) by adding at the end the following:

‘‘(9) PRIMARY STREAM.—A ‘primary stream’ is—

‘‘(A) the single digital stream of programming that prior to June 12, 2009 was substantially duplicating the programming transmitted by the television broadcast station as an analog signal; or

‘‘(B) if there is no such stream, the single digital stream of programming transmitted by the television broadcast station as a digital signal.

‘‘(10) PRIMARY TRANSMITTER.—A ‘primary transmitter’ is a television or radio broadcast station licensed by the Federal Communications Commission that is an appropriate governmental authority of Canada or Mexico, that applies a single distance signal equivalent value (referred to in paragraph (9)) to its secondary transmissions of such multicast stream that are made on or before June 30, 2010.

‘‘(11) MULTICAST STREAM.—A ‘multicast stream’ is a digital stream of programming transmitted by a television broadcast station that is not the station’s primary stream.

‘‘(12) SIMULCAST.—A ‘simulcast’ is a multicast stream of a television broadcast station that is substantially duplicating the programming transmitted by the primary stream or another multicast stream of such station.

‘‘(13) SUBSCRIBER.—The term ‘subscriber’ means a person or entity that receives a secondary transmission service from a cable system and pays a fee for the service, directly or indirectly, to the cable system.

‘‘(B) SUBSCRIBER.—The term ‘subscriber’ means to elect to become a subscriber.’’;

(9) TIMING OF SECTION 111 PROCEEDINGS.—Section 111(e)(1) is amended by striking ‘‘2005’’ each place it appears and inserting ‘‘2015’’.

(g) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) CORRECTIONS TO FIX LEVEL DESIGNATIONS.—Section 111 is amended—

(A) in subsections (c), (e), and (o), by striking ‘‘clause’’ each place it appears and inserting ‘‘paragraph’’;

(B) in subsection (o)(1), by striking ‘‘clauses’’ and inserting ‘‘paragraphs’’;

(C) in subsection (o)(2), by striking ‘‘subclause’’ and inserting ‘‘subparagraph’’.

(2) CONFORMING AMENDMENT TO HYPHENATE NONNETWORK.—Section 111 is amended by striking ‘‘nonnetwork’’ each place it appears and inserting ‘‘non-network’’.

(3) PREVIOUSLY UNDESIGNATED PARAGRAPH.—Section 111(e)(1) is amended by striking ‘‘second paragraph of subsection (i)’’ and inserting ‘‘subsection (f)(2)’’.

(4) REMOVAL OF SUPERFLUOUS ANDS.—Section 111(e) is amended—

(A) in paragraph (1)(A), by striking ‘‘and’’ at the end;

(B) in paragraph (1)(B), by striking ‘‘and’’ at the end;

(C) in paragraph (1)(C), by striking ‘‘and’’ at the end;

(D) in paragraph (1)(D), by striking ‘‘and’’ at the end; and

(E) in paragraph (2)(A), by striking ‘‘and’’ at the end.

(5) REMOVAL OF VARIANT FORMS REFERENCES.—Section 111 is amended—

(A) in subsections (f)(1), (f)(2), (f)(3), and (f)(4), by striking ‘‘variant forms’’;

(B) in subsection (i), by striking ‘‘and their variant forms’’;

(C) in paragraph 111(e) is amended in the matter preceding subparagraph (A) by striking ‘‘three territories’’ and inserting ‘‘five entities’’;

(h) EFFECTIVE DATE WITH RESPECT TO MULTICAST STREAMS.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), the amendments made by this section, to the extent such amendments assign a distant signal equivalent value to the secondary transmission of the multicast stream on or before June 30, 2009, shall take effect on the date of the enactment of this Act.

(2) DELAYED APPLICABILITY.—

(A) SECONDARY TRANSMISSIONS OF A MULTICAST STREAM BEYOND THE LOCAL SERVICE AREA OF ITS PRIMARY TRANSMITTER BEFORE 2009 ACT.—In any case in which a cable system was making secondary transmissions of a multicast stream beyond the local service area of its primary transmitter before the date of the enactment of this Act, a distant signal equivalent value (referred to in paragraph (1)) shall be assigned to secondary transmissions of such multicast stream that are made on or before June 30, 2010.

(B) MULTICAST STREAMS SUBJECT TO PREEXISTING WRITTEN AGREEMENTS FOR THE SECONDARY TRANSMISSION OF SUCH STREAMS.—In
any case in which the secondary transmission of a multicast stream of a primary transmitter is the subject of a written agreement entered into on or before June 30, 2009, between a cable system or an association representing the cable system and a primary transmitter or an association representing the primary transmitter, a distant signal equipped to provide local-into-local service to all DMAs and determines that such failure was willful, such failure must include—

'(i) the degree of control the carrier had over the circumstances that resulted in the failure; and
'(ii) the quality of the carrier's efforts to remedy the failure; and
'(iii) the severity and duration of any service interruptions.

'(D) SINGLE TEMPORARY WAIVER AVAILABLE.—An entity may only receive one temporary waiver under this paragraph.

(E) SHOWING NO FAULT.—For purposes of this paragraph, the term 'short market' means a local market in which programming of one or more of the four most widely viewed television networks nationwide as measured on the date of enactment of this subsection is not offered on the primary stream transmitted by any local television broadcast station.

'SEC. 105. CERTAIN WAIVERS GRANTED TO PROVIDERS OF LOCAL-INTO-LOCAL SERVICE TO ALL DMAS.

Section 119 is amended by adding at the end the following new subsection:

'(g) CERTAIN WAIVERS GRANTED TO PROVIDERS OF LOCAL-INTO-LOCAL SERVICE TO ALL DMAS.—

'(1) INJUNCTION WAIVER.—A court that issued an injunction pursuant to subsection (a)(7)(B) before the date of the enactment of this subsection shall waive such injunction if the court certifies that it no longer wishes to recognize the entity against which the injunction was issued as a qualified carrier.

'(2) LIMITED TEMPORARY WAIVER.—(A) STATEMENT OF ELIGIBILITY.—An entity seeking to be recognized as a qualified carrier under this section shall file a statement of eligibility with the court that imposed the injunction. A statement of eligibility must include—

'(i) a certification issued pursuant to paragraph (B),
'(ii) records of the qualified carrier, and
'(iii) a certification issued pursuant to clause (i).

'(B) STATEMENT OF ELIGIBILITY.—An entity seeking to be recognized as a qualified carrier shall file a statement of eligibility with the court referred to in paragraph (1) that includes the following:

'(i) an affidavit that the entity is providing local-into-local service to all DMAs;
'(ii) a request for a waiver of the injunction; and
'(iii) a certification issued pursuant to paragraph (B).

'(C) ESTABLISHMENT OF QUALIFIED CARRIER RECOGNITION.—

'(1) TEMPORARY WAIVER.—(A) STATEMENT OF ELIGIBILITY.—An entity seeking to be recognized as a qualified carrier under this subsection shall file a statement of eligibility with the court that imposed the injunction. A statement of eligibility must include—

'(i) an affidavit that the entity is providing local-into-local service to all DMAs;
'(ii) a request for a waiver of the injunction; and
'(iii) a certification issued pursuant to paragraph (B).

'(B) GRANT OF RECOGNITION AS A QUALIFIED CARRIER.—Upon receipt of a statement of eligibility, the court shall recognize the entity as a qualified carrier and issue the waiver under paragraph (1).

'(C) VOLUNTARY TERMINATION.—At any time, an entity recognized as a qualified carrier may file a statement of voluntary termination with the court certifying that it no longer wishes to be recognized as a qualified carrier. Upon receipt of such statement, the court shall reinstate the injunction waived under paragraph (1).

'(D) LOSS OF RECOGNITION PREVENTS FUTURE RECOGNITION.—No entity may be recognized as a qualified carrier if such entity had previously been recognized as a qualified carrier and subsequently lost such recognition or voluntarily terminated such recognition under subparagraph (C).

'(E) QUALIFIED CARRIER OBLIGATIONS AND COMPLIANCE.—

'(1) IN GENERAL.—An entity recognized as a qualified carrier shall continue to provide local-into-local service to all DMAs.

'(2) BURDEN OF PROOF.—In any proceeding made by a copyright holder to provide local-into-local service with a good quality satellite signal to at least 90 percent of the households in such designated market area (based on the most recent data published by the United States Census Bureau) at the time and place alleged.
“(G) Enforcement.—Upon motion filed by an interested party, the court recognizing an entity as a qualified carrier shall terminate such designation upon finding that the entity has willfully failed to provide local-into-local service to all DMAs, such failure shall result in the loss of recognition of the designated carrier and the termination of the waiver provided under paragraph (1), and the court may, in its discretion—

(i) impose a fine of not more than $250,000;

(ii) by striking ‘‘(3) EFFECTIVE DATE’’ each place it appears in clauses (i) and (ii), and inserting ‘‘July 20, 2004’’; and

(iii) by striking ‘‘manner other than by the use of a single reception antenna’’ each place it appears in clause (i), and inserting ‘‘manner other than by the use of a single reception antenna and associated equipment’’

(4) Failure to Provide Service.—If the court determines that the failure to provide local-into-local service to all DMAs has willfully failed to provide local-into-local service to all DMAs, such carrier shall retransmit such stations in the local market of such subscriber and associated equipment may be separate from such subscriber if—

(a) in the heading for subparagraph (A), by striking ‘‘analogue’’ each place it appears; and

(b) by striking ‘‘2004’’ and inserting ‘‘2009’’;

(ii) the quality of the entity’s efforts to remedy the failure and restore service; and

(iii) the severity and duration of the service interruption.

(5) Penalties for Violations of License.—A court that finds, under subsection (a)(6)(A), that an entity recognized as a qualified carrier has willfully made a secondary transmission of a primary transmission made by a network station and embodying a performance or display of a work to a subscriber who is not eligible to receive the transmission, shall—

(i) the degree of control the entity had over the circumstances that resulted in the failure;

(ii) the quality of the entity’s efforts to remedy the failure and restore service; and

(iii) the severity and duration of the service interruption.

(6) Penalties for Violations of License.—A court that finds, under subsection (a)(6)(A), that an entity recognized as a qualified carrier has willfully made a secondary transmission of a primary transmission made by a network station and embodying a performance or display of a work to a subscriber who is not eligible to receive the transmission, shall—

(i) the degree of control the entity had over the circumstances that resulted in the failure;

(ii) the quality of the entity’s efforts to remedy the failure and restore service; and

(iii) the severity and duration of the service interruption.

(7) Local-into-Local Service to All DMAs Defined.—For purposes of this subsection—

(A) In General.—An entity provides ‘‘local-into-local service to all DMAs’’ if the entity provides local service in all designated market areas (as such term is defined in section 1252(c)(2)) pursuant to the license issued to such entity.

(B) Household Coverage.—For purposes of subparagraph (A), an entity that provides available local-into-local service with a good quality signal to at least 90 percent of the households in a designated market area based on the most recent census data released by the United States Census Bureau shall be considered to be providing local service to such designated market area.

(C) Good Quality Satellite Signal Defined.—The term ‘‘good quality signal’’ has the meaning given such term under section 342(e)(2) of Communications Act of 1934.

SEC. 106. TERMINATION OF LICENSE.

(a) Termination.—Section 118, as amended by this title, shall cease to be effective on January 31, 2014.

(b) Conforming Amendment.—Section 4(a) of the Satellite Home Viewer Act of 1994 (17 U.S.C. 2119 note; Public Law 103-369) is repealed.

SEC. 107. SURCHARGE ON STATUTORY LICENSEES.

(a) Surcharge.—The Copyright Royalty Judges shall establish a surcharge or surcharges to be paid, in accordance with subsection (b), by cable systems subject to statutory licensing under section 111(c) of title 17, United States Code, and satellite carriers whose secondary transmissions are subject to statutory licensing under section 119(a) of such title, in addition to the royalty fees paid by such cable systems under section 111(d)(1) of such title and by such satellite carriers under section 118(b)(1) of such title.

(1) b. Surcharge under subsection (a) shall be assessed, during fiscal years 2009 through 2013, in amounts that, in the aggregate, will equal at least $250,000.

(b) Funds Unavailable for Obligation.—Surcharges collected under this section shall be deposited in the Treasury of the United States and shall not be available for obligation.

(c) Authority.—The Copyright Royalty Judges may exercise the authorities such judges have under chapter 8 of title 17, United States Code, to carry out this section.

SEC. 108. CONSTRUCTION.

Nothing in section 111, 119, or 122 of title 17, United States Code, including the amendments made to such sections by this title, shall be construed to affect the meaning of any terms under the Communications Act of 1934, except to the extent that such sections are specifically cross-referenced in such Act or the regulations issued thereunder.

TITLE II—COMMUNICATIONS PROVISIONS

SEC. 201. REFEREE.

Except as otherwise provided, whenever in this title an amendment is made to a section or other provision, the reference shall be considered to be made to such section or provision of the Communications Act of 1934 (47 U.S.C. 151 et seq.).

SEC. 202. EXTENSION OF AUTHORITY.

Section 325(b) is amended—

(1) in paragraph (2)(C), by striking ‘‘December 31, 2009’’ and inserting ‘‘December 31, 2014’’; and

(2) in paragraph (3)(C), by striking ‘‘January 1, 2010’’ each place it appears in clauses (i) and (ii) and inserting ‘‘January 1, 2015’’.

SEC. 203. SIGNIFICANTLY VIEWED STATIONS.

(a) In General.—Paragraphs (1) and (2) of section 346(b) are amended to read as follows:

‘‘(1) Service limited to subscribers taking local-into-local service.—This section shall apply only to retransmissions to subscribers of a satellite carrier who receive retransmissions of a signal from that satellite carrier pursuant to section 336.

‘‘(2) Service Limitations.—A satellite carrier may retransmit to a subscriber in high definition format the signals of stations from the local market of such subscriber, on January 1, 2005, the signal of a local network station affiliated with the same network to that subscriber if—

(II) In a case in which the satellite carrier makes available to that subscriber, on January 1, 2005, the signal of a local network station affiliated with the same television network pursuant to section 338, the carrier may only provide the secondary transmissions of the distant signal of a station affiliated with the same network to that subscriber if the subscriber’s satellite carrier, not later than March 1, 2005, submits to that television network the list and statement required to be submitted by a subscriber pursuant to section 338, the carrier may only provide the secondary transmissions of the distant signal of a station affiliated with the same network to that subscriber if—

(II) In a case in which the satellite carrier does not make available to that subscriber, on January 1, 2005, the signal of a local network station affiliated with the same network pursuant to section 338, the carrier may only provide the secondary transmissions of the distant signal of a station affiliated with the same network to that subscriber if—

(aa) that subscriber seeks to subscribe to such distant signal before the date on which such subscriber commences to carry pursuant to section 338 the signal’s signals to such subscriber from the local market of such local network station; and

(bb) the satellite carrier, within 60 days after such date, submits to each television network the list and statement required by subparagraph (F)(ii).

(ii) Special Circumstances.—A subscriber of a satellite carrier who was lawfully receiving the distant signal of a network station on the day before the date of enactment of the Satellite Home Viewer Act of 1994 may receive both such distant signal and the local signal of a network station affiliated with the same network until such subscriber chooses to no longer receive such distant signal from such carrier.

(III) Inclu...
(I) by striking ‘‘analog’’;

(II) in clause (i), by striking ‘‘the Satellite Home Viewer Extension and Reauthorization Act of 2004’’ and inserting ‘‘the Satellite Home Viewer Reauthorization Act of 2009’’; and

(III) by amending clause (ii) to read as follows:

‘‘(ii) either—

‘‘(I) at the time such person seeks to subscribe to receive such secondary transmission, resides in a local market where the satellite carrier is providing local service with a satellite network affiliated with the same network that is broadcast by a local station in the market where the subscriber resides, but such programing is not contained within the local station’s primary video;’’;

(v) in subparagraph (D), by striking ‘‘DISTRIBUTED’’;

(vi) in clause (ii), by striking (i), (iii) through (V), (vii) through (ix), and (xi);

(III) by redesignating clause (vi) as clause (i) and transferring such clause to appear before clause (ii); and

(IV) by amending such clause (i) (as so redesignated) to read as follows:

‘‘(i) SIGNAL TESTING.—A subscriber shall be eligible to receive a distant signal of a distant network station affiliated with the same network under this section if such subscriber is determined, based on a test conducted in accordance with section 73.686(d) of title 47, Code of Federal Regulations, or the testing procedures in section 73.686 of title 47, Code of Federal Regulations.’’;

(V) in clause (ii), by striking ‘‘digital’’ in the heading; and

(bb) by striking ‘‘digital’’ the first two places such term appears;

(cc) by striking ‘‘Satellite Home Viewer Reauthorization Act of 2009’’ and inserting ‘‘Satellite Home Viewer Reauthorization Act of 2009’’; and

(dd) by striking ‘‘whether or not such subscriber objects to subscribe to local digital signals’’;

(VI) by inserting after clause (ii) the following new clause:

‘‘(ii) STUDY CONSIDERATION.—In conducting the study under clause (i), the Commission shall consider whether to account for the fact that an antenna can be mounted on a roof or placed in a home and can be fixed or capable of rotating.

(iii) REPORT.—Not later than 1 year after the date of enactment of the Satellite Home Viewer Reauthorization Act of 2009, the Commission shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate a report containing—

(1) the results of the study conducted under clause (i);

(II) recommendations, if any, regarding changes to be made to Federal statutes or regulations under section 339 of the Communications Act of 1934 as in effect on the date of enactment of this Act.

(2) in subsection (b), by striking ‘‘Home Viewer Reauthorization Act of 2009’’; and

(3) in subsection (d), by striking ‘‘the Satellite Home Viewer Reauthorization Act of 2009’’; and

(4) in subsection (e), by striking ‘‘the Satellite Home Viewer Reauthorization Act of 2009’’.

SEC. 321. PROCESS FOR ISSUING QUALIFIED CARRIER CERTIFICATION.

(a) Certification.—The Commission shall issue a certification for the purposes of section 175(e)(3)(A)(i)(II) of title 17, United States Code, if the Commission determines that—

(1) a satellite carrier is providing local service pursuant to a ‘‘retail service’’ and not providing such local service as of the date of enactment of the Satellite Home Viewer Reauthorization Act of 2009—

(2) the satellite carrier’s satellite beams are designed, and predicted by the satellite manufacturer’s pre-launch test data, to provide a quality satellite signal to at least 50 percent of the persons in each such designated market area based on the most recent census data released by the United States Census Bureau; and

(3) there is no evidence that there has been a satellite or sub-system failure subsequent to the satellite’s launch that
precludes the ability of the satellite carrier to satisfy the requirements of subparagraph (A).

(b) INFORMATION REQUIRED.—Any entity seeking the certification provided for in subsection (a) shall submit to the Commission the following information:

(1) In submitting that, to the best of the applicant’s knowledge, the satellite carrier provides local service in all designated market areas pursuant to the statutory license in section 122 of title 17, United States Code, and listing those designated market areas in which local service was provided as of the date of enactment of the Satellite Home Viewer Reauthorization Act of 2009.

(2) For each designated market area not listed in paragraph (1):

(A) Identification of each such designated market area and the location of its local receive facility.

(B) Data showing the number of households, and maps showing the geographic distribution thereof, in each such designated market area based on the most recent census data released by the United States Census Bureau.

(C) Maps, with superimposed effective isotropically radiated power predictions obtained in the satellite manufacturer’s pre-launch testing, that the center of the carrier’s satellite beams as designed and the geographic area that the carrier’s satellite beams are designed to cover are predicted to provide a satellite linked to at least 90 percent of the households in such designated market area based on the most recent census data released by the United States Census Bureau.

(D) For any satellite relied upon for certification under this section, an affidavit stating that, to the best of the applicant’s knowledge, there have been no satellite or sub-system failures subsequent to the satellite’s launch that would degrade the design performance to such a degree that a satellite transponder used to provide local service to any such designated market area is precluded from delivering a good quality satellite signal to at least 90 percent of the households in such designated market area based on the most recent census data released by the United States Census Bureau.

(E) Any additional engineering, design, or other information that the Commission considers necessary to determine whether the Commission shall grant a certification under this section.

(c) DETERMINATION.—For the purposes of subparagraph (A), the 100 designated market areas shall be as determined by Nielsen Media Research and published in the Nielsen Station Index Directory and Nielsen Station Index United States Television Household Estimates or any successor publication as of the date of a satellite carrier’s application for certification under this section.

SEC. 207. NONDISCRIMINATION IN CARRIAGE OF NONCOMMERCIAL EDUCATIONAL TELEVISION STATIONS.

(a) IN GENERAL.—Section 122(c)(1) of title 17, United States Code, is amended by adding at the end the following new paragraph:

(5) NONDISCRIMINATION IN CARRIAGE OF HIGH DEFINITION SIGNALS OF NONCOMMERCIAL EDUCATIONAL TELEVISION STATIONS—

(A) EXISTING CARRIAGE OF HIGH DEFINITION SIGNALS.—If, prior to the date of enactment of the Satellite Home Viewer Reauthorization Act of 2009, an eligible satellite carrier is providing, under section 122 of title 17, United States Code, any secondary transmissions to subscribers located within the local market of a television broadcast station of a primary transmission made by that station, then such satellite carrier shall continue to transmit signals of noncommercial educational television stations located within that local market in accordance with the following schedule:

(1) By December 31, 2010, in at least 50 percent of the markets in which such satellite carrier transmits secondary transmissions in high definition;

(2) By December 31, 2011, in every market in which such satellite carrier provides such secondary transmissions in high definition.

(B) NEW INITIATION OF SERVICE.—If, after the date of enactment of the Satellite Home Viewer Reauthorization Act of 2009, an eligible satellite carrier initiates the provision, under section 122 of title 17, United States Code, of any secondary transmissions in high definition to subscribers located within the local market of a television broadcast station of a primary transmission made by that station, then such satellite carrier shall continue to transmit the high-definition signals of noncommercial educational television stations located within that local market, subject to the following:

(i) Models of satellite antennas normally used by the satellite carrier’s subscribers;

(ii) the same calculation methodology used by the satellite carrier to determine a predicted signal availability in the top 100 designated market areas; and

(iii) taking into account whether a signal is in standard definition format, compression methodology, modulation, error correction, power level, and utilization of advances in technology that do not circumvent the intent of this section to provide for non-discriminatory treatment with respect to any comparable television broadcast station signal, a video signal transmitted by a satellite carrier such that—

(I) the satellite carrier transmits all television broadcast stations’ signals the same with respect to statistical multiplex prioritization; and

(II) the number of video signals in the relevant satellite transponder is not more than the then current greatest number of video signals carried on any equivalent transponder serving the top 100 designated market areas.

(C) DETERMINATION.—For the purposes of subparagraph (A), the 100 designated market areas shall be as determined by Nielsen Media Research and published in the Nielsen Station Index Directory and Nielsen Station Index United States Television Household Estimates or any successor publication as of the date of a satellite carrier’s application for certification under this section.

SEC. 208. SAVINGS CLAUSE REGARDING USE OF NON-COMPULSORY LICENSES.

(a) IN GENERAL.—Nothing in this title, the Communications Act of 1934, or regulations promulgated thereunder by the Federal Communications Commission under this title or the Communications Act of 1994, or any regulations issued by the Copyright Royalty Tribunal under section 325(b) of the Communications Act of 1994, shall preclude the ability of the satellite carrier that is not a party to a carriage contract with a qualified noncommercial educational television station, or its representative, that is in force and effect as of the date of enactment of the Satellite Home Viewer Reauthorization Act of 2009:

(1) by redesigning paragraphs (6) through (9) (as previously redesignated) as paragraphs (7) through (10), respectively, and

(2) by inserting after paragraph (5) (as so redesignated) the following new paragraph:

(6) QUALIFIED NONCOMMERCIAL EDUCATIONAL TELEVISION STATION.—The term ‘qualified noncommercial educational television station’ has the meaning given such term in section 615(c)(1) of this Act.

SEC. 209. SAVINGS CLAUSE REGARDING DEFINITIONS.

Nothing in this title or the amendments made by this title shall be construed to affect—

(1) the meaning of the terms ‘program related’ and ‘primary video’ under the Communications Act of 1934; or

(2) the meaning of the term ‘multicast’ in any regulations issued by the Federal Communications Commission.

TITLE III—REPORTS

SEC. 301. DEFINITION.

In this title, the term ‘appropriate Congressional committees’ means the Committees on the Judiciary and on Commerce, Science, and Transportation of the Senate and the Committees on the Judiciary and on Energy and Commerce of the House of Representatives.

SEC. 302. REPORT ON MARKET BASED ALTERNATIVES TO STATUTORY LICENSING.

Not later than 1 year after the date of the enactment of this Act, and after consultation with the Federal Communications Commission, the Register of Copyrights shall submit to the appropriate Congressional committees a report containing—

(1) proposed mechanisms, methods, and recommendations on how to implement a phase-out of the statutory licensing requirements set forth in sections 111, 119, and 122 of title 17, United States Code, by making such sections inapplicable to the secondary transmission of a performance or display of a work embodied in a primary transmission of a broadcast station that is authorized to license the same secondary transmission directly with respect to all of the performances and displays embodied in such primary transmission;

(2) any recommendations for alternative means to implement a timely and effective transition of the statutory licensing requirements set forth in sections 111, 119, and 122 of title 17, United States Code; and
The SPEAKER pro tempore. Is there objection to the request of the gentleman from Michigan?

There was no objection.

Mr. CONYERS. I yield myself such time as I may consume.

Madam Speaker and Members, H.R. 3570 extends the compulsory copyright license for satellite television providers for another 5 years, as Congress has done in each of the last two other cycles that this measure has been reauthorized.

This is an important intellectual property law and will also make a number of critical updates and much-needed clarifications to the compulsory copyright licenses for both satellite and cable television. Passage of this legislation before the end of the year is crucial. We must pass this bill in both bodies by December 31. If we don’t pass this bill, thousands upon thousands of satellite television subscribers will lose their signals.

In addition to simply reauthorizing the license, the bill ambitiously tackles several other issues for consumers, including critical updates to copyright law and the need for alternative means of distributing programs to consumers.

In addition, the bill provides an audit right to content owners so they can be sure that they are being fairly compensated for the use of their intellectual property. It significantly increases penalties for copyright infringement under the licenses and updates the licenses to reflect the national digital television transition.

The Judiciary Committee marked this bill up in September and reported it with a unanimous vote of 34-0. Since the markup, we have worked with the Energy and Commerce Committee, which has jurisdiction over communications policy. The bill that we vote on today is a combined Judiciary and Commerce bill. Title I contains the Judiciary piece on copyright. Title II contains the Commerce piece on communications. The components of the bill have done their best to respect each other’s jurisdiction, and I thank the chairman of the committee for his cooperation.

Since the markup, we have made further improvements to the language. We’ve attempted to address some concerns expressed by members of the committee. The changes include: harmonizing the so-called “grandfathering” provisions in the bill with those in the Energy and Commerce bill to ensure that consumers who lawfully received programming are not abruptly cut off because of changes in the law; providing a method for calculating the value of multicast programming schemes under the section 111 license; strengthening the protections for copyright owners in the qualified carrier provision, which provides an incentive for a satellite carrier to serve every market in the United States; increasing the threshold of the national emergency provisions; and authorizing a study of how the compulsory licenses may be phased out in favor of direct negotiation for copyrights over time without disrupting the television marketplace.

Title I also includes a savings clause to make absolutely clear that the changes we make and issues we address have no application to communications law unless specifically mentioned. The committee is amending the cable and satellite licenses to reflect the digital transition—something new—and multicasting, in particular, as it pertains to copyright law only. Nothing in this title should be used as a basis for conclusions concerning cable and satellite regulation in areas where Congress has not yet spoken.

Among the many Members who contributed to this progress, I would like to single out in particular my good friend Mr. S. Smith from Texas, and Mr. Conyers from Michigan, who serves in the dual role as a senior member of the Judiciary Committee and the Chair of the Telecommunications Subcommittee. I also must thank Lamar Smith, the ranking member of the Judiciary Committee, for helping us to improve the bill in several ways. Of course the distinguished chairman of Energy and Commerce, Mr. Conyers, who serves in the dual role as the senior member of the Judiciary Committee and the Chair of the Telecommunications Subcommittee. I also must thank Lamar Smith, the ranking member of the Judiciary Committee, for helping to improve the bill in several ways. The distinguished chairman of Energy and Commerce, Mr. Conyers, who serves in the dual role as the senior member of the Judiciary Committee and the Chair of the Telecommunications Subcommittee. I also must thank Lamar Smith, the ranking member of the Judiciary Committee, for helping to improve the bill in several ways.

We’ve been working on these issues for more than a year now, and the result is a consensus bill among just about all of the industry stakeholders, including satellite and cable companies, studios, sports leagues, public television and several others. Most importantly, it’s a bill that improves service to television consumers and fosters efficiency and competition between cable, satellite, and broadcasters. The satellite license expires in less than a month, December 31, and we must have this reauthorized without delay to avoid the immediate loss of service to tens of thousands of satellite consumers.

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its jurisdiction over subject matters contained in the bill which fall within its Rule X jurisdiction.

Further, I request your support for the appropriation of the appropriate number of Members of the Committee on Homeland Security to be named as conferees during any House-Senate conference convened on H.R. 3570 or similar bills. I also ask that a copy of this letter and your response be included in the legislative report on H.R. 3570 and in the Congressional Record during floor consideration of this bill.

I look forward to working with you as we prepare to pass this important legislation.

Sincerely,

BENNIE G. THOMPSON,
Chairman.

HOUSE OF REPRESENTATIVES
COMMITTEE ON THE JUDICIARY,
Washington, DC, October 28, 2009.

Hon. Bennie G. Thompson,
Chairman, Committee on Homeland Security,
House of Representatives,
Washington, DC.

Dear Mr. Chairman: Thank you for your letter regarding your Committee’s jurisdictional interest in H.R. 3570, the Satellite Home Viewer Update and Reauthorization Act of 2009.

I appreciate your willingness to support expediting floor consideration of this important legislation today. I understand and agree that this is without prejudice to your Committee’s jurisdictional interests in this or similar bills in the future. In the event a House-Senate conference on this or similar legislation is convened, I would support your request for an appropriate number of conferees.

Per your request, I will include a copy of your letter and this response in the Committee report, as well as in the Congressional Record in the debate on the bill. Thank you for your cooperation as we work towards enactment of this legislation.

Sincerely,

JOHN CONYERS, Jr.,
Chairman.

I urge my colleagues to support this important legislation, and I reserve the balance of my time.

Mr. SMITH of Texas. Madam Speaker, I yield myself as much time as I may consume.

H.R. 3570, the Satellite Home Viewer Reauthorization Act of 2009, in my judgment, is the single most important copyright bill Congress will consider this year. The legislation combines two separate bills: H.R. 3570, which was introduced by Chairman CONYERS and reported by the Judiciary Committee on September 16, 2009, and H.R. 2994, which is the Energy and Commerce Committee’s related measure that contains amendments to the Communications Act.

The combined bill extends the compulsory license in section 119 of the Copyright Act that authorizes satellite carriers to deliver distant network programming to subscribers. Far fewer consumers rely upon this license to receive network programming than in past years, but there still remain about 1 million households that will lose such programming if the license is not extended beyond the end of this year, which is when it is currently due to expire. To avoid this outcome, the bill extends the compulsory license an additional 5 years to December 31, 2014. My hope is that this will be the last time Congress needs to reauthorize what was originally envisioned to be a temporary license.

H.R. 3570 also contains a number of significant amendments to the cable license in section 111 of the Copyright Act governing the retransmission of both local and distant programming, and the local programming license in section 122 that governs the satellite retransmission of local-into-local programming. The most significant immediate changes in the new license is a negotiated resolution of the phantom signal liability issue that I appreciate the chairman including in this bill.

I commend Chairman CONYERS for his decision to expand this reauthorization beyond the narrow limits of the expiring section 119 provisions. While circumstances prevented us from being able to iron out all the wrinkles from these related licenses, I’m pleased we were able to make substantial improvements for some of the most urgent concerns. Among the elements for which there was bipartisan support to include in this bill are provisions that, one, modernize a license to account for digital broadcasting; two, afford the ability of consumers to continue to receive lifeline network programming; three, make clear that copyright owners are generally entitled to a royalty for each stream of multicast programming; and four, establish new rules to permit copyright owners to make sure they are being paid the royalties they are entitled to.

Madam Speaker, I have strong reservations about the decision to permit DISH Network to again benefit from section 119’s distant signal license in light of its prior record of willful infringement. However, I share the goal of making sure more Americans can benefit from satellite delivery of local programming into local markets. I am grateful for Chairman CONYERS’ recognition of the seriousness of these concerns and his willingness to work with me and Chairman Berman to strengthen the deterrent and enforcement provisions in the bill. The enhanced penalties we’ve included for any future violation, along with provisions that require the GAO to audit DISH for its compliance with the law and DISH to certify its compliance to the Federal District Court, reflect substantial improvements from previous versions of the bill. The incorporation of these provisions reflect a carefully negotiated and fair compromise.

Madam Speaker, I urge my colleagues to support H.R. 3570, the Satellite Home Viewer Reauthorization Act. When enacted, this bill will both preserve and expand the ability of Americans to view vital network and independent station programming without interruption.

Madam Speaker, again, I want to thank the chairman for working with us to come up with a good bipartisan product. And this bipartisan effort, by the way, has gone on since last February.

I would now like to recognize several staff members on both sides of the aisle who have contributed so much to the success of this legislation. Those staff members are being paid the royalties they are entitled to.

Mr. SMITH of Texas. With that, I will reserve the balance of the time.

Mr. CONYERS. Madam Speaker, I would like to insert into the RECORD at this point a more detailed description of the changes that have been made in the bill since it was introduced.

EXPLANATION OF CHANGES TO SHVRA INTRODUCTION

The Committee believes that the licenses in Sections 111 and 119 should be updated to accommodate the growing practice of multicast broadcasting, by which television stations transmit multiple streams of digital television programming over a single broadcast signal. While the Committee has endeavored to avoid including any provisions that would interfere with existing communications law and regulation, the Committee has been cognizant of the interplay between the copyright and the communications elements of the legislation and intends to confine its amendments to the copyright licenses only.

In addition to addressing issues raised by multicasting in the 111 and 119 licenses, this bill addresses important concerns raised by Members on both sides of the aisle.

The penalties for willful and large-scale infringement of the license have been increased, and some damages now go directly to the pool of copyright owners.

The qualified carrier provisions have also been clarified and strengthened. While nothing in the qualified carrier provisions reported by the Committee lessened the qualified carrier’s obligation to comply with all aspects of the Section 119 license, the Committee recognizes that the royalty and household eligibility requirements of the Section 119 license should not be overshadowed by the qualified carrier’s unique commitment to provide local-into-local service to all 210 markets. Therefore, the bill provides for at least one compliance examination and a certification requirement for the qualified carrier.

Finally, the bill responds to some Members’ concerns about the continued necessity of these compulsory copyright licenses by providing for a study of policy alternatives that may enable Congress to phase out the licenses without unfairly altering the television market or diminishing the value of the copyrights involved.

RECOMMENDATION OF DISH WITHOUT A MULTICASTING DISH

With the transition from analog to digital technology, questions have arisen as to how digital streams shall be treated for cable
royalty purposes. The definitions in Section 111 have been amended to address the multiple digital streams that television stations are now able to transmit. The definition of “primary stream” now includes the primary stream and any multicast streams transmitted by a television station. The “local service area” definition has been amended to clarify that the primary stream of a television broadcast station and any multicast streams of that station have the same local service area. For example, if the FCC determines that a television broadcast station is “significantly viewed” in a particular area, that area will be part of the local service area for all of the station’s digital streams for purposes of Section 111. This definition is relevant to the Copyright Act only, and is not intended to create any inference as to the carriage obligations and rates for cable multicast streams, which are the exclusive jurisdiction of the Communications Act and the Federal Communications Commission.

The calculation of royalties under the cable license has been amended to value multicast signals. The “distant signal equivalent” definition now specifies that each non-simulcast primary and multicast stream carried outside of its local service area will be subject to a separate royalty payment calculation by cable operators and will be evaluated separately to determine its distant signal equivalent value assignment. Section 111 has been amended to pay less than full DSE rates where FCC rules permit only a portion of a distant signal to be carried. This amendment gives the same treatment to multicast streams. The significantly viewed status of a primary stream under the FCC rules and regulations also applies to the multicast streams of the same television station to determine their local status for royalty purposes. However, the 3.75 percent “market quota rate” and the “syndicated exclusivity” surcharge royalty rates are only applicable for retransmission of primary streams, and are not applicable to secondary transmission of multicast streams.

In order to clarify the different types of digital streams that may be offered by television stations, definitions for “primary stream,” and “multicast stream” have been slightly amended. For example, the FCC has added for “simulcast stream,” in Section 111. A “primary stream” is the digital stream that a television station is entitled to demand under the statute and the system is established within the station’s local service area under the FCC’s rules in effect on July 1, 2009. A “multicast stream” is any digital stream transmitted by a television station other than the primary stream.

The Committee recognizes that some broadcasters may use their multicast streams to create “simulcast” streams—i.e., streams that duplicate the programming on the broadcaster’s primary stream or on other multicast signals. In such cases, the broadcaster may transmit the same content on two streams, but one stream will be in high definition format and the other will be in standard definition. In such instances, a DSE value will be assigned only to one of the duplicating streams. The Copyright Office may, as multicasting evolves, determine whether there are other circumstances in which two streams should be considered duplicating.

The definitions of “network station,” “independent station,” and “noncommercial station” have been slightly amended. The new definition of “network station” incorporates the conditions that the station must meet to be deemed a network station for royalty purposes. Thus, to be considered a network station for royalty purposes, a multicast stream must transmit all or substantially all of the programming from an interconnected program service that (a) is owned and operated by only one company that supplies the nationwide programming for a substantial part of the typical broadcast day and (b) offers programming on a regular basis for 15 or more affiliated television station licensees located in at least 10 states. These revisions do not alter the statutory definition of “network station” as it applies to a primary stream. DSE values are applied to individual multicast streams as of the date of enactment, except where a cable system was retransmitting a simulcast stream prior to that date, in which case the assignment of a DSE value to that multicast stream shall commence on July 1, 2010. Separately, DSE values have been added to a cable system subject to an agreement requiring carriage of multicast streams that was entered into prior to July 1, 2009 will not be retroactively applied before that date.

The Committee also believes that simply because Congress changes the law, law-abiding copyright owners do not automatically suffer damages. The Committee anticipates that the Comptroller General will take precautions to ensure that compliance with its examination does not burden the qualified carrier any more than is necessary to examine the qualified carrier’s observance of the proper royalty payment, prior to the effective date. A significant element in any implementation is the license’s standards for eligible house- holds. Only if the Comptroller General, in consultation with the Register of Copyrights, determines that there is substantial likelihood that a copyright owner could bring a successful infringement action will a second examination be initiated.

The bill also responds to concerns expressed by the Committee Members at the mark-up. It increases transparency and accountability by the qualified carrier concerning its obligations to copyright owners. A certification provision similar to the one passed by the Committee on Energy and Commerce has been added. It requires the satellite carrier to certify to the district court and the Copyright Office that it remains compliant with the license and that it paid any royalties due. The bill also provides that households that subscribed to distant signals on a substantial national basis. Statutory damages of up to $2,500,000 are now available for each 3-month period of infringement. Furthermore, these vastly increased damages will be split among copyright owners.

IV. STUDY OF ALTERNATIVES TO COMPULSORY LICENSES

Despite these improvements, the Committee is aware that the compulsory license is not a perfect system. It is, however, deeply entrenched in the current cable and satellite television industries, and cannot be eliminated without causing serious disruption for both the industries and the consumers. The compulsory license expires at the end of the year and must be reauthorized, but we know that the tele- vision marketplace and broadcast technology will continue to evolve. This legislation provides for a study of whether the licenses can be eliminated in the future, and how this marketplace change should transition away from the licenses.

Madam Speaker, I yield with pleasure to Chairman BOUCHER.

Mr. BOUCHER. Madam Speaker, I thank the gentleman from Michigan for yielding the customary 10 minutes to the Energy and Commerce Committee.

At this time, I would like to yield such time as he may consume to the
This is Mr. WAXMAN, the chairman of the Committee on Energy and Commerce, and Mr. BOUCHER, the chairman of the Subcommittee on Communications, Technology, and the Internet as well as Subcommittee Ranking Member STEARNS for their hard work on this issue. Mr. BOUCHER has been working on these issues since the first satellite TV bill in 1988, and he and his staff have been a tremendous resource for all of us as this bill has moved forward. Of course I also want to thank and recognize Mr. BARTON and his staff for their work on this legislation. This has been a bipartisan effort from the start of the 111th Congress, and I appreciate the cooperative manner in which this legislation was processed.

This bill is an important step forward for the communication provisions of this bill update the Communications Act to account of the transition to digital television. The bill makes changes to the existing rules on “significantly viewed” signals in an attempt to balance competition between satellite and cable companies. It directs the FCC to study issues that directly impact consumers, and it establishes a regime that should bring for the first time satellite-delivered local television programming. It also provides “local-into-local” service, to communities throughout the country that currently lack such service.

These can be arcane issues, but they determine the availability of satellite-delivered video programming to American households. It involves communications and copyright law, and we need, as technology evolves, to revisit the issues and strike the right policy balance.

The task of combining separate Energy and Commerce and Judiciary Committee bills into a single product was complex and time consuming, but the final product is a balanced, bipartisan measure. I would like to commend Chairman CONYERS, Ranking Member SMITH and Judiciary Committee staff for working cooperatively with the Energy and Commerce Committee to produce a final bill. I note that the bill before us incorporates the language from H.R. 2994 as well as H.R. 3570. H.R. 3570 was referred solely to the Committee on the Judiciary, while H.R. 2994 was referred solely to the Committee on Energy and Commerce.

The members of both committees worked diligently on their respective bills to address issues within the jurisdiction of each committee, and both committees filed reports on their separate bills.

Accordingly, the legislative history of H.R. 3570 incorporates the legislative history of H.R. 2994. The Judiciary Committee’s title of this bill concerns the use of compulsory copyright licenses by cable and satellite companies to retransmit broadcast television programming.

The reauthorization and refinement of these provisions will serve to promote competition for pay television services and to ensure that consumers can continue to benefit from this competition.

The Judiciary Committee wisely chose to address for the first time the existence of the so-called “multicast” signals and how these signals are being treated with respect to the compulsory copyright license. It is important to note, however, that the Judiciary Committee’s treatment of multicast signals does not, and should not, have any bearing on the treatment of multicast signals in other regulatory or statutory contexts.

Simply put, the treatment of multicast in title I of this bill is limited to the specific language of the Communications Act to take account of the transition to digital television. It is imperative that the way multicast signals are treated under copyright law cannot be confused with the way multicast signals are treated under communications law. Similarly, it’s important that the communications law provisions of this bill do not affect copyright law beyond what is explicitly intended by the act.

To address this concern, the legislation includes savings clauses that make clear that the melding of two complicated statutes should not lead to changes in title 47 or title 17 beyond what is explicitly intended by the act.

In sum, I believe we have before us a carefully crafted bill that strikes the right balance among an array of complicated legal and policy matters. The bill is good for consumers, and I urge my colleagues to vote to approve this legislation.

Mr. STEARNS. Madam Speaker, I yield myself such time as I may consume.

My colleagues, this bill is about a hundred pages, and the Judiciary Committee had probably the majority of this bill. We start at page 74 in title II, and the preponderance is in the Judiciary. But the bill is critical in the sense that this act itself is going to expire at the end of this month and we need to make sure that the DTV transition.

This has been a great display of bipartisanship. We had two committees. The Judiciary Committee and the Energy and Commerce Committee had separate bills just like they have in the Senate. The Senate has a separate bill in their Commerce Committee and also in the Judiciary. But we’ve come together, and it’s a tribute to Mr. BOUCHER and Mr. WAXMAN as well as Mr. BARTON that we came together here in the House to provide for high-definition programming and to get this to the Senate.

This was an important provision of this bill. As we’ve already discussed, the satellite home viewer act expired. My colleagues, we’re hoping for a favorable negotiation, but I think it’s been outlined pretty clearly, some of the aspects about it, so I’m going to concentrate on the areas that deal with telecommunications, a committee I serve as the ranking member.

The Communications Act provisions make clerical and substantive changes to reflect the end of analog broadcasting. That’s a statement in itself with the new digital spectrum. It also requires an FCC report on whether the signal strength and antenna standards for distant signal eligibility should be modified in light of the DTV transition. They implement the deal DISH has struck with broadcasters to regain authority to provide distant signals if they offer local-into-local service in all 210 markets. They clarify that nothing in this act affects must-carry rights. They clarify that if a subscriber starts receiving from their satellite operator pro-

Mr. BOUCHER. Madam Speaker, I yield myself such time as I may consume.

(Rep. BOUCHER asked and was given permission to revise and extend his remarks.)

Mr. BOUCHER, Madam Speaker, in a collaborative process, the House Energy and Commerce, the Judiciary Committees are presenting to the House this afternoon a renewal of the Satellite Home Viewer Act, provisions of which are scheduled to expire at the end of this year. The provisions of this act entitle the delivery of satellite-distant network signals to homes that cannot receive network programming from a local television station.

I think that’s true. While it still contains, in this bill, a provision we opposed in the committee during the markup that tries to twist DISH’s arm into carrying public broadcasting stations in high-definition format, and I was the one that spoke against this, the additional views in the committee report reflect our concerns, and there is a chance that provision will become moot since, obviously, the parties are in negotiation, and we’re hoping for a favorable negotiation so that will work itself out.

Madam Speaker, I reserve the balance of my time.

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We're taking the opportunity of this reauthorization to achieve a long-held goal of having all 210 local television markets across the Nation uplinked by satellite for retransmission of those local stations back into the market of their original. The goal is to ensure that their retransmission will be able to reach the 28 rural local TV markets that we have identified that are receiving both of the major satellite television services, as well as the local television stations that serve their area.

At the present time, there are 28 local television markets in rural areas in various places of the Nation that do not have local television signals delivered by either of the major satellite television carriers, and much of our effort this year has been directed toward finding a way to obtain satellite carriage of these 28 rural markets for local television signals.

Earlier this year, following extensive discussions with the company, I received a letter from EchoStar, a company commonly known in the trade as the DISH Network, agreeing to uplink for local retransmission all 210 local television markets upon certain conditions. One condition is that the company receive the ability in our legislation to import into the markets distant signals in order to supply the missing networks in the markets that do not have a full complement of the networks represented by local affiliates. The bill that we're presenting today grants that permission if EchoStar, in fact, provides local TV service in all 210 television markets nationwide.

Another condition of the company's willingness to serve all 210 markets is that the law not impose new carriage obligations that the company would have to devote its satellite capacity in order to meet. While the bill does impose some new carriage obligations, I'm optimistic that they will not be so extreme as to prevent EchoStar from starting service in all 210 local markets over the coming year.

Providing local TV service in the 28 currently unserved local markets will make local TV news, sports, weather, emergency information, and locally originated programs available in every part of the Nation, a goal that we're now very close to achieving. Serving the 28 now unserved local TV markets involves a major expenditure by EchoStar for ground-based facilities in each of the currently unserved markets and for the launch, in 2010, of a new satellite that itself will cost hundreds of millions of dollars.

I want to commend EchoStar for expressing a willingness to make these very substantial investments if we pass legislation that meets the conditions I have previously described, and I think our legislation does. I also commend television broadcasters and DirecTV, the other major satellite television provider, both of which groups played a high role in our negotiations proceeded. And I want to thank the gentlewoman from California (Ms. Eshoo) and adopted during Commerce Committee consideration of our bill.

I want to say thank you this afternoon to Chairman Conyers and his excellent staff for the cooperation with my staff and with me as our two committees structured the bill that we present to the House this afternoon. And I want to say thank you to the gentleman from Texas (Mr. Smith) and the gentleman from Florida (Mr. Stearns) for the highly constructive and cooperative bipartisan role that they have played in helping us move this measure through our two committees.

Madam Speaker, I urge approval of the bill, and I reserve any time I may have remaining.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. STEARNS. Madam Speaker, I yield 3 minutes to the gentleman from Texas (Mr. Barton), the distinguished ranking member of the Energy and Commerce Committee.

Mr. Barton of Texas asked and was given permission to revise and extend his remarks.

Mr. BARTON of Texas. I thank the gentleman from Florida for yielding.

Madam Speaker, I rise in support of the Satellite Home Viewer Update and Reauthorization Act of 2009. I want to particularly commend the leadership of the Energy and Commerce Committee and the Judiciary Committee for working with the minority. This is one of those rare instances in this Congress when there has been bipartisan cooperation and the result is a bill that both sides can support.

The bill itself is an example of what Congress should be about. It is an authorization bill with a finite authorization—in this case, 5 years—that authorizes the transfer of satellite signals with the transition from analog to digital television broadcasting. The industry today is much different than it was 20 years ago when we first authorized the Satellite Home Viewer Act, and this bill reflects that. As we are transitioning to digital television and high-definition television, this bill takes those technical advances into consideration, which I think is a good thing.

There is one provision in the legislation that is nettlesome from my point of view. We have adopted a provision that I opposed in committee that forces the DISH Network to carry high-definition signals for public broadcast stations. I'm not opposed to public television being broadcast in high definition, but I don't think it's the end of the world if DISH chooses for right now not to carry those signals because they're engaged in an upgrade of their business model until 2013. So congressional intervention in this bill in that case is something that I wish was not in the bill. There is a chance, however, that the parties will negotiate and this provision of the bill will become moot by the time the bill moves to the other body.

With that said, Madam Speaker, this is a good piece of legislation. I want to compliment Ranking Member STERNs, who's worked very hard on it, and the staffs on both sides of the aisle for their hard work, and I would hope the House will pass this bill at the appropriate time.

Mr. CONYERS. Madam Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. STEARNS. Madam Speaker, it is my pleasure to yield as much time as she may consume to the gentlelady from Tennessee, Marsha Blackburn.

Mrs. BLACKBURN. Madam Speaker, I do rise in support of the updated version of the bill, which we have heard discussed on this floor tonight, is much more than just a convenience or an ‘I want to see TV’ issue. For us, it is an issue of health and safety and public safety. And by working to expand the definition of the unserved customer, which we have done on a bipartisan basis in this bill, my constituents in rural west Tennessee counties like Hardin and Hardeman and Chester are now going to be able to watch the distant satellite signal that we’ve discussed.

The reason it is important for us is because a couple of years ago, we had a devastating tornado that swept through west Tennessee and touched down in our district. Nearly three dozen Tennesseans were killed and 150 people were seriously injured. Communities were paralyzed and had significant difficulty in receiving news alerts and communicating.

By fixing this short market, we will all rest a little better knowing that should we be faced with any other such disaster of this magnitude, that we will be better prepared and able to respond and to persevere.

I do want to take a moment to thank Chairman CONYERS, Chairman BARTON, Ranking Member BARTON, and Ranking Member STEARNS for all of their hard work in fixing this short market issue and helping to resolve this issue for my constituents in Tennessee.

As has been said, the bill's not perfect, and there is an area that has been mentioned mandating that a private
company like DISH Network carry public broadcasting in high def. It really does go against free market principles. I do know that is going to continue to be worked on. We are looking forward to getting that issue resolved.

I thank the gentleman from Florida. Mr. STEARNS. Madam Speaker, how much time do I have left?

The SPEAKER pro tempore. The gentleman from Florida has 7 1/2 minutes.

Mr. STEARNS. I yield such time as she may consume to the gentlelady from Wyoming (Mrs. LUMMIS).

(Mrs. LUMMIS asked and was given permission to revise and extend her remarks.)

Mrs. LUMMIS. I would like to thank the chairman and ranking member of the Judiciary Committee for the inclusion of language from my bill on statewide public television. Passage of this legislation will remove the legal obstacles for satellite carriers to offer statewide public television in Wyoming and other States. I don't care whether it's in high def or not. I just want public television carried in Wyoming and other States, and that's what's been achieved. So thank you kindly.

I also thank the gentleman from Georgia (Mr. DEAL) who worked diligently to address the problem of local television market areas. Despite his good work, I rise today to express regret for the missed opportunity the passage of this bill represents.

The decision to put off for another 5 years any real reform to the system of designated market areas carries with it very negative consequences for the citizens of my State. Out of Wyoming's 23 counties, 16 do not have satellite access to Wyoming-based stations. Over half of all television households in Wyoming do not have access to local television.

For a rural State like Wyoming, satellite sometimes represents the only viable option to receiving television programming. The inability to receive local channels and access to local content and severely limits the reach of emergency notifications.

Emergency situations, like the butane tank truck that recently overturned on an icy highway during a blizzard, should serve as proof that the availability of local stations on satellite television is not just an entertainment issue. The DMA system may make sense for the densely populated areas in the East, but it has created an absurdity in the sparsely populated areas of the West. I am grateful for the inclusion of a study to find a better way to determine what the local market is.

But, Madam Speaker, people in Wyoming do not need a study to tell them that when their network TV station originates 400 miles away from a different State, they are not receiving the local content they need. For this reason, I cannot support passage of this bill despite its tremendous improvements.

Mr. JOHNSON of Georgia. Madam Speaker, I rise today in support of H.R. 3570, the Satellite Home Viewer Update and Reauthorization Act of 2009. I strongly support this important piece of satellite television reauthorization legislation. H.R. 3570 reauthorizes satellite operators' licenses to import distant network affiliate television signals to households that cannot receive stations in their own local markets. This is important as it allows satellite and cable television providers to carry out-of-market television signals to households that cannot receive stations in their own local markets. This allows state public television networks to reach all their residents with important news and public affairs programming.

Alongside the chairman, I worked hard to get the phantom signal language included in the bill. I am proud of the final product and believe it is something about which all Americans can be proud.

Previously, due to flaws in existing law, broadcasters sometimes paid royalties to content producers even when programming was not actually delivered to subscribers. Royalties for the transmission of broadcast signals to cable systems were paid as if the entire cable system received the transmission, even if it was only received by some subscribers within the cable system. This has been known as the phantom signal problem. The cost of this flaw was passed down to consumers. With the current message to Congress regarding my anti-phantom signal language, the American people will no longer be forced to pay for programming they have not received. I join the chairman in urging my colleagues to support this bill. As a result of this legislation, constituents in my district will not be forced to pay for satellite and cable programming they have not received and, as a result, save money in this economy.

Mr. STEARNS. Madam Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Michigan (Mr. CONyers) that the House suspend the rules and pass the bill, H.R. 3570, as amended.

The motion was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being present agree with the motion of the Chair.

Mr. CONyers. Madam Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. The Chair's prior announcement, further proceedings on this motion will be postponed.

COMMUNICATION FROM THE CHIEF ADMINISTRATIVE OFFICER OF THE HOUSE

The SPEAKER pro tempore laid before the House the following communication from the Chief Administrative Officer of the House of Representatives:


HON. NANCY PELOSI, Speaker, House of Representatives, Washington, DC.

DEAR MADAME SPEAKER: This is to notify you formally, pursuant to Rule VIII of the Rules of the House of Representatives, that I have been served with a subpoena for production of documents issued by the U.S. District Court for the District of Connecticut, in connection with a criminal matter now pending in the same court.

After consultation with the Office of the General Counsel, I have determined that compliance with the subpoena is consistent with the precedents and privileges of the House.

Sincerely,

DANIEL P. BEARD.
Mr. MCGOVERN. Madam Speaker, first I want to commend President Obama for thinking long and hard about the course that he believes the United States should take in Afghanistan. That kind of deliberation is a welcome change from the previous administration. But now the President has reached the wrong conclusion. Sending 30,000 more U.S. troops to Afghanistan will make it 30,000 times harder to extricate ourselves from this mess. If our fight is truly with al Qaeda, then we’re in the wrong country. They have moved to Pakistan. Indeed, General Jones has told us that there are maybe less than 100 al Qaeda members in Afghanistan. With the troop increase announced by the President last night, we will have over 100,000 service men and women in Afghanistan. Do we really need 100,000 troops to go after less than a hundred al Qaeda?

President Karzai is corrupt and incompetent. He cheated in the most recent national election. And 90 percent of his votes was rigged. I don’t want any more American service men or women to risk their lives for his corrupt government; and I am a little bit stunned, quite frankly, by the quick and inexplicable pivot by the administration from denouncing Karzai’s behavior to now embracing our support for Karzai actually discredits us with the Afghan people. We have seen that it is exceedingly difficult to train Afghan troops, many of whom are not only illiterate, but unable to add or subtract.

The cost of this escalation will be enormous, both in terms of blood and treasure. We will need to borrow billions and billions of additional dollars to pay for this policy.

Madam Speaker, at a time of great economic crisis here in the United States, I would suggest that rather than nation-building in Afghanistan, we should do a little more nation-building here at home.

It is important to note that the so-called timeline outlined by the President last night envisions the beginning of drawing down our troops in July of 2011—the beginning, not the end. Does anybody really believe that we will not be deeply ensnared in Afghanistan well beyond 2011?

Madam Speaker, I do not and I never will give up hope that the Afghan people. They have suffered greatly over the last several decades. We must continue to support meaningful economic development and political assistance.

But usually, Madam Speaker, there is another important issue here, and that is congressional involvement. I know the President last night cited the resolution to authorize force in 2001 as providing the authority that he needs. I would argue that it was not Congress’ intent in 2001 to authorize decades of nation-building in Afghanistan. We voted to go after the people who committed the horrible atrocities on September 11. I would urge that before a final decision is made that the United States Congress have the chance to fully debate his proposal and have an up-or-down vote.

Under the Bush administration, what usually happened is that additional troops were deployed and then later, once they were already in theater, the administration would submit a supplemental request. That is backwards. We should debate and vote on this critical issue before we send additional troops.

CLIMATEGATE

The SPEAKER pro tempore (Mr. GARARANDEZI). Under a previous order of the House, the gentleman from Texas (Mr. POE) is recognized for 5 minutes.

Mr. POE of Texas. Mr. Speaker, over the past several weeks, I have come to light of fraud and corruption in the global warming scientific community. Or, as it is now called, the climate change community.

These shady scientists have made claims of a global warming apocalypse and created fear in the world that we are all doomed because man is the enemy destroyer of planet Earth. But now thousands of their emails were recently leaked to the public. These emails, written by scientists at the British University of East Anglia like Phil Jones, the director of the climate change community.

These emails show numerous actions taken to silence the dissenting voices and withhold the actual information being used to make their questionable claims.

The British university says they are going to release all of their data now, but the scientists have already admitted that they destroyed much of that data. Obviously, they destroyed the data that shows their theory on climate change is a fraud on the world. That doesn’t look like sound science to me. It sounds like they have cooked the books. It sounds like they have picked out an outcome and are trying to fix the data to make it say what they want it to say. It sounds like a political agenda.

World economies depend on these claims that have been manipulated. The U.N. global warming summit in Copenhagen that starts next Monday, December 7, is using this tainted information. The United Nations wants to exert more control over energy and emissions, and the sovereignty of nations using information that is apparently now faulty. It is tainted with scandal, and it is deceitful.

How can the American people trust any of these claims when they have been manipulated. The American public can be fooled no longer by these pseudo scientists. One may ask why would these scientists skew the facts? Well, it is obvious. Governments all over the world give climate change individuals in the climate change crowd millions of dollars of money to study climate change. And if manmade climate change is a falsehood, these scientists may fear that their money will dry up.

The jury is still out on the global warming theory and the climate change myth. But Congress must address any legislation based on this theory regarding manmade climate change, we ought to have an open, honest debate from real scientists who didn’t manipulate the evidence to get an outcome-based conclusion. Further, the EPA should halt all carbon emission regulations of the energy community until we learn the facts about climate change. Honesty is a prerequisite for conclusions about climate change legislation. And now we know that climate change is not a well settled scientific fact at all, whether the mad scientists at the University of Anglia like that fact or not.

And that’s just the way it is.
HIV/AIDS PROGRAMS

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Florida (Ms. ROES-LEHTINEN) is recognized for 5 minutes.

Ms. ROES-LEHTINEN. Mr. Speaker, yesterday on World AIDS Day, the administration released its annual 2009 fiscal year strategy for the President’s Emergency Plan for AIDS Relief, otherwise known as PEPFAR. The strategy is required by the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008. That is a mighty long name, but it does so much good. And it begins to shift PEPFAR from an emergency program to one focused on sustainability.

Mr. Speaker, the challenges in fighting HIV/AIDS are daunting, but not insurmountable. Over 33 million people worldwide are infected, an estimated 67 percent of whom live in Sub-Saharan Africa. Nearly 2.7 million people, including 430,000 children, were newly diagnosed with HIV last year. Over 14 million children have lost one or both parents to HIV/AIDS. AIDS is decimating an entire generation of the most productive members of society in developing countries, which will cause GDP to drop by more than 20 percent in the hardest-hit countries over the next decade.

Without effective prevention, treatment, and care efforts, the AIDS pandemic will continue to spread its mix of disease, despair, and death that is destabilizing governments and societies and undermining the security of entire regions.

But one need not travel to Africa or the Caribbean or Eastern Europe to witness the devastation of HIV/AIDS; we need only to look out the front door. In my home State of Florida, Mr. Speaker, an estimated 90,000 people are living with HIV/AIDS, making us third in the Nation in the number of AIDS cases.

My home county of Miami-Dade ranks second among large metropolitan areas for people living with AIDS with over 32,000 currently diagnosed. These individuals need our assistance. They are fighting this disease.

On October 21 of this year, with a bipartisan majority, we voted in Congress to reauthorize the Ryan White HIV/AIDS Treatment Extension Act. The program has been the largest supplier of services for those living with HIV/AIDS in the United States. In the United States, over 500,000 people a year benefit from the Ryan White program. Florida alone received over $200 million in funding with Ryan White funds in 2009, and has been able to assist countless low-income Americans living with HIV/AIDS.

Fully appreciative of the challenges here at home, I am proud to have supported PEPFAR since its inception. To date, PEPFAR has been a highly effective and results-oriented program. For example, more than half of the 4 million people receiving lifesaving drugs in low- and middle-income countries around the world are directly supported through PEPFAR. PEPFAR has supported care for more than 10 million people affected by HIV/AIDS, including more than 10 million orphans and vulnerable children. At least 240,000 babies have been born free of HIV/AIDS thanks to PEPFAR prevention of mother-to-child transmissions.

The achievements of our bilateral programs are truly remarkable. However, the record of our multilateral organizational support is weak. While we need more robust burden sharing—particularly as the World Health Organization has revised its guidelines and vastly expanded the pool of people who require access to treatment—significant revelations of corruption in the global fund programs are cause for great concern.

Mr. Speaker, we must work together to ensure accountability, transparency, and maximum effectiveness of multilateral programs that are receiving our United States support. We must work to ensure that every dime that is dedicated to PEPFAR, including our contributions to the global fund, is used for its intended purposes and delivered in the most effective, transparent, and sustainable manner possible. We must ensure that those precious resources actually reach those who are in need, without being diverted to line the pockets of unaccountable international bureaucrats or corrupt regimes.

Lastly, we must also preserve the conscience clause and promote behavior modification, particularly abstinence and fidelity, under the new strategy.

In closing, let us recommit ourselves to saving the future by helping to save lives afflicted with HIV/AIDS.

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California (Ms. WOOLSEY) is recognized for 5 minutes.

(Ms. WOOLSEY addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

AMERICAN TROOPS IN AFGHANISTAN

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Texas (Ms. DOUGETT) is recognized for 5 minutes.

Mr. DOUGETT. Mr. Speaker, after the tragedy of 9/11, I voted for the resolution that authorized military action against those who attacked us, including sending our troops into Afghanistan. We sent a strong, unified message that we will never yield to terrorism. We have not just the right but the duty to keep America secure. I certainly agreed with taking out Osama bin Laden. It is outrageous that the Bush administration lied to us in order to stop him, unnecessarily prolonging this conflict, strengthening our enemies as their attention and our resources were diverted to an ideologically driven invasion of Iraq.

Surely all Americans should respond affirmatively to President Obama’s call last night for unity of purpose in keeping our families secure and overcoming all of those who wish us harm. I agree with so very much of what President Obama said, but not so much with what and how he said he would accomplish our shared goal. The truth is he had an excellent and easy alternatives, and I applaud his deliberative effort. But the path to peace and security will not be found through a wider war. It is wholly unrealistic to expect that we can escalate our military forces in the hope of achieving a landscape of Afghanistan by another 40 percent, then deescalate and begin bringing them home all within a mere 18 months.

We have been fighting in Afghanistan on an installment plan. A few more troops, a few more months, and a whole lot more money—billions. There is no way that 2011 will mark the end of this war or even the beginning of the end. This is just a mirage. In 18 months the results may vary, but an installment will be requested in what is already a deteriorating war that has lasted 8 years with the illusive end of the war always just over the horizon.

The better exit strategy is to have fewer troops who need to exit. We should honor the sacrifice of those who are courageously serving and put fewer of them into harm’s way. It should not take 100,000 highly equipped and trained American troops to defend less than 100 al Qaeda in Afghanistan, an estimate yesterday from the President’s National Security Adviser.

Once again, we hear talk of a grand coalition, but make no mistake, it is Americans who are being asked to bear the overwhelming share of the burden. As these troops would arrive in Afghanistan, the Canadians, the Dutch, they have already announced they will be bringing their troops home at the same time our people get there.

The French and the Germans have said not one more troop. Spain may increase its total to 1,200. Iceland has two, Luxembourg has nine. Every bit of help counts certainly, but it’s clear that the great amount of blood that will be split will, once again, be American. The cost will be to the American taxpayer.

Now, United States Army doctrine, as written by General Petraeus, calls for one counterinsurgent for every 50 members of the population. In Afghanistan, with a population of 30 million, that would work out to about half a million additional troops, not 30,000. Whatever the exact number is, it is clear that to meet the military’s own objectives, more installments are in order. All this effort to prop up a corrupt Karzai government that just stole $50 million additional troops, a few more months, and a whole lot more money—billions. There is no way that 2011 will mark the end of this war or even the beginning of the end.

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\[1815\]
My fellow Americans, we must chart a better course. Congress has a constitutional responsibility to scrutinize this request carefully as well as how to pay for it, to find a better way to achieve our shared goals of protecting every American family. To do otherwise is to dangerously foist a war on families unable to control the situation in Afghanistan that can consume, as it has throughout human history, as many lives and as many dollars as we are willing to expend there. And such a painful, unending sacrifice may well make our families less, not more, secure.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from North Carolina (Mr. Jones) is recognized for 5 minutes.

(Mr. Jones addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

THE QUAGMIRE OF AFGHANISTAN

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. Paul) is recognized for 5 minutes.

Mr. Paul. Certainly, in the last 24 hours, we've had a lot of discussion about Afghanistan and whether or not we should send more troops. As a matter of fact, that debate has been going on for a long time. The whole debate about Afghanistan is something that makes me think that we are bogged down, considering the fact that it has been going on for 8 years.

This is not new for us. This is more or less the rule rather than the exception, and I believe this comes about because of the way we go to war. In the last 60-some years, we have never had a declaration of war, but we have been involved in plenty. We've been involved in Korea, the Persian Gulf, and the Iraq War, and now Afghanistan, and it looks like it's going to be Pakistan as well.

So I think the reason we get here is because we don't declare war and we slip into war, and then it becomes political. There are two sides. There is one side of the argument that says, Let's just come home. And the other side says, Fight it all out. And people say, No, you can't be an extremist on this. You have to have a balance. And the balance is chaotic. There's no way of measuring victory, and nobody wants to give up, claiming it would be humiliating to give up.

But just think of the tragedy of Vietnam, all those years and all those deaths and all that money spent. Eventually we left, and South Vietnam is now a unified country, but we still have troops in Korea, in Europe, and in Japan, and we are bankrupt. So some day we are going to have to wake up and look at that type of foreign policy that the Founders advised us to have, and that is nonintervention: don't get involved in the internal affairs of other nations, have free and open trade and accept friendship with other countries who offer it, and that we shouldn't be the policemen of the world and we shouldn't be telling other people what to do. We cannot be the policemen of the world and pay for all those bills because we are literally bankrupt.

In thinking about the dilemma that we have, I think back, even back in the 1960s when I was an Air Force flight surgeon for 5 years, and that was the first time I heard the term "quagmire," and I'm talking about that for many, many years, that's all I can think about right now is to evaluate what we have. There are a few phrases that have been around for a long time, and I believe they more or less describe what is happening here, Quagmire. Certainly that is what we are doing. We are digging a hole for ourselves, "perpetual war for perpetual peace." We have all heard that term, and it sounds like we are in perpetual war. "War is the health of the state." We all know about the government size and sacrifice of civil liberties always occurs much more so in the midst of a war.

A book was written many years ago by one of the most, if not the most, influential war thinkers, Smedley Butler. He wrote a book called "War is a Racket." And I have come to believe that war literally is a racket for the people who push these wars, whether it's the military industrial complex or the special interests and the various factions, but it's never, it's never for the people.

Today it is said that we're over there to protect our national security to get into Afghanistan. Well, it's down to 100 al Qaedas in Afghanistan, and, quite frankly, the Afghan Government had nothing to do—they said they harbored the al Qaeda, and that is true, but do you think those 19 guys needed to do pushups in Afghanistan to come over here and say, what? The real training wasn't in Afghanistan. It was in Spain. It was in Germany. Where was the real training? The real training was in Florida. The training was in Florida, and the FBI had evidence at the time that they were being trained, and it's totally ignored. And yet we are concentrating, we are still back to 9/11, fear of nuclear war. We have to go in, scare the people.

Yet what is the motivation for individuals to become radical against us, whether it's Osama or al It. The real training in Afghanistan? There is one single factor that is the most influential in motivating somebody to commit suicide terrorism against anybody or us, and that is occupation by a foreign nation. And now, where have we occupied? We have occupied Iraq and Afghanistan. We are bombing Pakistan. But not only the literal occupation, but also, we have this threat on Pakistan.

So I would say it is time for us to reassess ourselves and look at a non-interventionist foreign policy.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Oregon (Mr. DeFazio) is recognized for 5 minutes.

(Mr. DeFazio addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

RECOGNIZING THE GENEROSITY OF ROSS PEROT'S GIFT TO THE U.S. ARMY COMMAND AND GENERAL STAFF COLLEGE FOUNDATION

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Kansas (Mr. Moran) is recognized for 5 minutes.

Mr. Moran of Kansas. Mr. Speaker, I rise this evening in the House of Representatives to recognize a remarkable gift that will enhance the professional education of our country's military officers and thereby improve the safety and security of every American.

In November, Mr. Ross Perot of Texas pledged $6.1 million to support two new initiatives at the U.S. Army Command and General Staff College located at Fort Leavenworth, Kansas. At a time when our country is demanding more and more from those who defend our freedom, this significant contribution will ensure that America's military leaders receive the best education and training to accomplish their missions around the world.

Mr. Perot's contribution followed a recent visit to Fort Leavenworth. He experienced firsthand the classroom instruction that U.S. officers and their interagency and international counterparts receive at the Army's Command and General Staff College, our country's oldest and largest military staff college. He also met with students and toured the Lewis and Clark Center, an impressive new building completed in 2007 to house the college.

Mr. Perot's gift will fund a new center for interagency cooperation and a new chair of ethics. As the conflicts in Iraq and Afghanistan make clear, cooperation between military and other agencies is an important component for our country's success. To address this need, the Col. Arthur D. Simons Center for Study of Interagency Cooperation will enhance the cooperation of interagency affairs. The second initiative to be created, the Gen. Hugh Shelton Chair in Ethics, will attract world-class academics and researchers to stress the importance of ethics and values in the military.

You may notice that rather than naming these new programs after himself, Mr. Perot chose to name them after others. Col. Arthur "Bull" Simons led the 1970 Son Tay raid to free prisoners of war in Vietnam, as well as a 1979 mission to rescue, from a prison in Tehran, two of Mr. Perot's employees. Retired Army Gen. Hugh Shelton served as Chairman of the Joint Chiefs of Staff and is a friend of Mr. Perot's. Mr. Perot selflessly named his initiatives after military members who have played an important role in his life and...
SMALL BUSINESS IS AMERICA’S ECONOMIC ENGINE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Georgia (Mr. BROUN) is recognized for 5 minutes.

Mr. BROUN of Georgia. Mr. Speaker, the economic engine that pulls along the economic train of prosperity in America is being derailed. America’s entrepreneurs, America’s small business men and women are this country’s economic engine. They are the backbone of our economy. They create most of the new jobs here in America.

Mr. Speaker, they have waited long enough for the so-called stimulus to kick in. In fact, they have been waiting far too long. Mr. Speaker, where are the jobs? It’s time for us to scrap this failed policy. It’s time for Congress to stop wasting taxpayer time and money. It’s time to give a real jolt to the economy and stop talking so much through high taxes and more debt.

Mr. Speaker, I introduced H.R. 4100, the JOBS Act, to do just that. My bill, the Jumpstarting Our Business Sector, or JOBS Act, is a commonsense and simple solution to our discussion on job creation. It provides a 2-year moratorium on capital gains and dividends taxes, two taxes which directly inhibit or derail a business’ ability to reinvest their revenue into creating new jobs. It reduces the two lowest tax brackets by 5 percent. It cuts the payroll tax rate and the self-employment tax rate in half for 2 years. Additionally, it reduces the corporate tax rate by 10 percent for 2 years.

In fact, the United States already has the second lowest corporate tax rate in the world. It’s incredible that our economy has prospered for this long under such an extraordinary tax burden.

At this time of great economic turmoil, it’s only logical to curtail this massive tax and allow our business sector to propel us back onto a stable economic footing.

Finally, just as important, my JOBS Act recoups any and all unspent stimulus dollars, putting them to work instead of towards waste.

Now is the time for a new way forward. For 11 months, the so-called stimulus was being trialed. Unfortunately, it has failed. But there is no reason to keep going down the same track and throwing taxpayers’ money down a rat hole towards a failed plan. And there is certainly no reason to keep sending money into Georgia’s imaginary congressional districts, double zero, 27, 86, or any others that the government has identified.

The American people demand something better than more government and more debt. They deserve more, something better than more unemployment insurance and COBRA extensions. We need to stop handing them dead fish and, instead, hand them a fishing pole.

It’s time to give a real jolt to the economy. It’s time for us to scrap this stimulus that we have waited far too long. Mr. Speaker, where are the jobs? It’s time for us to stop wasting taxpayer time and money. It’s time to give a real jolt to the economy and stop talking so much through high taxes and more debt.
have loans from local banks, and they get those loans at a reasonable interest rate because many small businesses are very good and prompt payers. The bank trusts them. The bank knows that the small business is solvent, that they run a good operation, that they're doing good work in the community, so the bank is taking that risk and is loaning that money at a fairly reasonable rate of interest, so the small businessman has this money or this liquidity in order to support the things that he needs in his business.

Just to give an example, perhaps, of a farmer. A farmer has a nice piece of land and he decides he wants to raise some crops. But in order to do that, he needs a tractor. He doesn't have enough money to buy that tractor right off the bat with cash, and so he gets a loan from the bank to buy the tractor, and then he uses the tractor to grow crops and to produce a product which we call food. In the meantime, he makes profit on selling his food, he makes payments to the bank to pay for his tractor. It's a simple example, but what is required for jobs and for small businesses to operate is liquidity. That is money, that's available at a reasonable interest rate in order to facilitate the growth of businesses, particularly small businesses, and jobs. If there is not good liquidity, not a good source of money, then you're going to have a problem with jobs.

A fourth enemy of job creation is uncertainty. Again, put yourself in the shoes of that small businessman. You look out on the horizon and you see all kinds of things that you don't know what's going on, and you're worried about what's going on. You know as you look out at the horizon that there's talk of gasoline taxes, that used to be low are going to go up. There's talk of energy taxes, heavy taxes, on a new health care bill. There's the possibility of energy shortages; there's the possibility of anything that might be disruptive to your business. Well, that uncertainty is going to have the effect of saying, hey, before I stick my neck out and do something new, I think I'm going to just instead sit back a little bit and wait, because I don't want to be too far leveraged. I don't want to make too much of a commitment because I don't know if it's going to happen or not. As body is buying ammunition and hoarding gold, and everybody's nervous and concerned. There's talk about this, that and the other. So when you get uncertain, uncertainty makes it hard for business people to want to add jobs, and it may reduce jobs. Businesses work well when they have a plan. They know that they're going to have so many orders for so many years, they know that they're going to build, they can plan out, buy their materials, get the crews, get the manpower. And so, when you want to mess up job creation and business, all you do is introduce a lot of fear and uncertainty and you're guaranteed to be hurting jobs.

A fifth thing that is going to be harmful to job creation is a whole lot of red tape and regulations. If you're thinking about taking on some new projects, you see just mountains of red tape, regulations, and all kinds of legal fees and problems and in front of you that the government has created, then you're going to be a little bit more reluctant to jump into that project. I'll give you an example. For instance, let's say you're a power company and you have a number of coal-fired power plants. You take a look at what's going on, and you take a look at the technology that's available and you say, you know, I think that it would really make a lot of sense to build a nuclear plant because coal prices are going up. We know that nuclear is safe. We know it doesn't generate any CO2, so that should make people that are worried about global warming happy, and we think that it makes sense to put a nuclear power plant. But then you start to think and say, Wait a minute. What are the regulations? What are the red tape? And how does this work? And you start to learn about what the government give you a permit to operate it, and you find out, oh my goodness, we apply for a license, and after we get done building the plant, which is going to cost millions and millions of dollars, then the government will tell us whether or not we can operate it. That doesn't make sense. Doesn't the government give you a permit to operate the plant first, then you put the millions in and run the plant because you got the permit? No, you've got to get a permit to begin with, but you don't ever get any for sure that you can run that plant until after you've built it. Well, that would be an example of red tape and regulations making it so, hey, I'm not going to make that decision. I'm not going to take on that job of building some big plant and a more efficient way to generate electricity because of the fact that we've got all this red tape and regulations in the way.

And then I would suggest that there is a sixth thing that's a job killer, and that is the excessive spending on the part of the Federal Government. When the Federal Government spends a whole lot of money, it has the net effect of eventually costing businesses and people, money that they spent and all. And so that the idea of doing what's sometimes called stimulus or spending actually is an enemy to jobs. We're going to get into that a little bit further along this evening. But I thought it would be important to start by defining our terms. Jobs are important for all of us. That's what you need to pay your mortgage. That's what you need to pay the food bill for your wife and kids. Jobs are an important thing in America, and Americans want to have jobs. And so what we've got is something to work on anyway, a good project or some work to do and they have a sense of paying off the mortgage and working their way toward the dream of a more prosperous future. And so these are the enemies of jobs. I'm going to review them one more time.

First of all, a slow economy. Second, high taxes. Third, uncertainty. Not enough liquidity. That is money. Fourth, uncertainty or fear. Fifth, red tape and government regulations. And sixth, the idea of excessive Federal spending, because that comes back in the form of taxes and reducing liquidity.

I am joined this evening by a very good friend of mine, Congressman SCALISE, who has a very good sense of business and a good sense of humor and is always a great contributor to our little Wednesday evening discussions.

My good friend from Louisiana, please join us.

Mr. SCALISE. I want to thank my friend from Missouri. We have been having these discussions for I guess the past few Wednesdays for a few months now. I appreciate the gentleman for hosting this hour that's become a regular tradition, not only to talk about the things that are happening in the country, but really to focus in on the jobs that have actually taken here in this Congress by this Democratic leadership that have actually led us to the decline in jobs that we're facing today. Of course, so many Americans remember the month; now back in the beginning of this year when President Obama stood right there, right there on that well behind you, and talked about the need for a stimulus bill, a bill that spent $787 billion of money that we don't have, money that was borrowed from our children and grandchildren, and he said it had to happen so that we would stop unemployment from exceeding 8 percent.

Now, of course today, as we look at 10.2 percent unemployment, the American people are asking, where are the jobs? And, of course, when the White House came out with this Web site, and the White House and the President bragged about the transparency, and, in fact, the President talked about the fact that the American people would be able to track every dollar, and even said that Vice President JOE BIDEN would be in charge of tracking the money, and the American people would be able to go to a Web site and see how that money was spent and how it's creating all these jobs. Of course you and I opposed that bill because we knew it wouldn't create jobs. In fact, we knew it would help actually lead to more unemployment because it would add so much more money to our national debt, money that we couldn't afford to spend, and money that was going to hurt small businesses and in fact did hurt small businesses.

Mr. AKIN. I would think it's important to think that the points that you're making are very, very good. I just want to recap what you're saying. I had, just as we got started, talked
about things that kill jobs. And one of the things that kills jobs is excessive government spending. The first thing that you came to, ironically, was this supposedly stimulus bill which the President and the Democrat leadership thought was going to improve the economy, and they were right. That was what they claimed. In fact, the claim was, as you and I recall, that if we did not pass this $787 billion unfunded supposedly stimulus bill, we might get unemployment as high as 8 percent. They passed that stimulus bill, and now unemployment is 10.2 percent. So that suggests just what we’re talking about, that excessive government spending is, instead of making the situation better, will make it worse. But we were promised, as you were saying, by the administration, by the Democrat President, that this was going to create some jobs; and so they created a whole Web site, recovery.gov, and this is where the President said people could go and find out and track every dollar that’s being spent, and it’s going to be fully transparent. I guess maybe the White House didn’t think that people were actually going to take him up on his offer. But of course the American people did. As people started going to that Web site, we had uncovered this about 2 weeks ago. When you would go to the Web site, we found out first of all those of us in Louisiana found out that we had about 45 congressional districts because they actually had a listing of how many jobs were created in Louisiana’s 45th Congressional District. And, of course, they showed that more jobs were created from the stimulus bill in Louisiana’s Eighth Congressional District than in the district I represent, the First Congressional District. The only problem is that Louisiana has seven congressional districts. And so many people in Louisiana were not only asking, where are the jobs, but where is this Eighth Congressional District?

Mr. AKIN. I just want to stop you because what you’re saying, people are going to think that this is either a comedy or a fiction.

Mr. SCALISE. Well, in fact, they created a Web site called recovery.gov, and this is where the President said people could go and find out and track every dollar that’s being spent, and it’s going to be fully transparent. I guess maybe the White House didn’t think that people were actually going to take him up on his offer. But of course the American people did. As people started going to that Web site, we had uncovered this about 2 weeks ago. When you would go to the Web site, we found out first of all those of us in Louisiana found out that we had about 45 congressional districts because they actually had a listing of how many jobs were created in Louisiana’s 45th Congressional District. And, of course, they showed that more jobs were created from the stimulus bill in Louisiana’s Eighth Congressional District than in the district I represent, the First Congressional District. The only problem is that Louisiana has seven congressional districts. And so many people in Louisiana were not only asking, where are the jobs, but where is this Eighth Congressional District?

Mr. AKIN. I just want to stop you because what you’re saying, people are going to think that this is either a comedy or a fiction.

You’re saying that we put millions of Federal dollars into creating a Web site to let people know where the jobs were being created by this supposedly stimulus bill, and whoever it was that was hired said that the jobs are going into an Eighth and a Ninth and a Tenth district, which is where they are in Louisiana. That’s amazing.

Mr. SCALISE. Not only that—and maybe this would be a comedy if it was fiction. The problem is, this is not fiction. This is reality. This is what the White House actually had on their Web site that was supposedly showing the transparency and accountability for all the tax dollars that they said that they would display how that money was being spent. That is actually what they inquired about this and our local newspaper, the Times Picayune of New Orleans, did a little digging of their own and called the White House and said, How is it that you can have this Web site and you’re showing districts that don’t even exist, showing jobs created in places that don’t exist? What is really going on here?

The first thing the White House said is, We’re not certifying the accuracy of the information. That was the quote from the White House. The group that said they would be the most transparent administration in history, when finally tasked with showing the American people where billions of dollars of money have been spent, their answer was, We’re not certifying the accuracy of the information.

And then, if I can follow up, they actually went further and they said, Okay, let’s just say you’re not certifying the information, but you’re actually showing on your Web site districts—and this just isn’t in Louisiana. We found this in Arizona and Kentucky. Probably Missouri.

Mr. AKIN. I heard Oklahoma had 99 districts.

Mr. SCALISE. They were showing districts that didn’t exist all across the country, and they were bragging about the jobs that were created in those districts that didn’t exist, those phantom districts. So they said, Well, how is it that you can show on your Web site a district that doesn’t even exist? The answer from the White House—and that is that the tax—pay money, this is money our children and grandchildren are going to have to pay back, money that you and I said should not have even been spent in the first place because it was money we don’t have, and it wasn’t going to create jobs—and they asked the White House to follow up, and they said, How is it that you can show information that’s false on your Web site? The White House’s answer was, Who knows, man, who really knows. That was the best they could do, and the American people deserve better.

Mr. AKIN. This is a million-dollar Web site created by the White House, the Obama administration. They come up with districts that don’t exist in various States. And when asked—what was the quote again? This is brilliant. This is really academic. Who knows, man, who really knows. Hey, far out, dude. I mean, Woodstock lives.

What are you talking about here? They’re using—using districts that don’t exist, claiming that jobs have been created; and yet here we are on the floor, we’re not necessarily wiz-
and then they had the stimulus bill and then they had the budget that doubled the national debt in 5 years.

And then after cap-and-trade they came with the health care bill, the government takeover of health care, which they’re doing as they tell their constituents. Of course, President Obama is using that as his top priority when the American people are saying, We don’t want a government takeover of health care; we want you to reform things that are broken. And we’ve presented legislation to actually fix the things that are broken—to lower costs, to address pre-existing conditions—the real problems American families are having with health care. But what American families don’t want to see is the government take over all of health care and literally shift the hundred million more people onto a Medicare system that’s already struggling to make ends meet. And senior citizens know that.

So what they’re asking is: stop dealing with policies that are actually running more jobs out of our country. Go and help create jobs in small businesses by lowering tax rates. And guess what’s going to happen here on the House floor tomorrow? The Democratic majority is actually going to introduce a bill to make permanent the death tax at a 45 percent tax rate. That’s going to kill small businesses in this country. And that’s their priority instead of creating jobs.

Mr. AKIN. If I could just ask you to yield back, everything you said is exactly spot on, and it is the solution to trying to deal with unemployment. But I think what I’d like to, if it’s possible, just for a minute, get a little philosophical here and talk about the fact that when you take a look at the political parties, in general these are two different ideas about what you do when you’ve got problems with unemployment.

One of them was proposed by a little British economist by the name of Lord Keynes. He was accompanied in his mischief with a fellow by the name of Morgenthau, who was FDR’s Secretary of the Treasury. That idea was called “stimulating the economy.” The idea was that if the government will just spend enough money, it’s going to create demand, and therefore the whole economy will run. It appeals to me as an engineer about just as much as the idea of you going in, grabbing your bootstraps, and try to lift yourself so you can fly around the room. But the idea is that when you’ve got a bad economy, the government should spend money like mad and it’ll “stimulate the economy.” And so that was one theory.

Another theory that was developed—and that usually is the Democrat theory, although not entirely—the other theory is: get your foot off the spending and the taxing, leave enough money in the company and, particularly with small business owners, to allow them to invest. When they invest, they create jobs and you allow the free market and you allow Americans, in the ingenuity of Americans and freedom, to motivate and to build a country bigger and stronger than it was before. And by doing that the economy gets stronger because individual citizens, not the government, are the ones that are creating and the taxing, leaving enough money in the pocket of the small businesses, in the hope that they are going to take that money and invest off like a rocket in all three instances.

The other example, I want to run back to. You’ve got this guy Morgenthau and he was 1939. Now we have turned a recession into the Great Depression. And Morgenthau comes before the Ways and Means Committee. This is something that happened long enough that people around here should know something about it. This was the buddy of little Lord Keynes. And this is what he told Congress. We’re spending more than we have ever spent before—and it does not work. And he goes on to say, After 8 years of the administration, we have just as much unemployment as when we started. And we’ve added an enormous debt to boot. This is FDR’s guy that was one of the original stimulus people.

So when I hear people say stimulus—this is the result of stimulus: it’s unemployment. It turns a recession into a depression. Mr. Speaker, did we try in April or May of this last spring? We tried the same dumb idea. And guess what? We’re getting the same lousy results. No big surprise.

So there are two ways to approach unemployment when you’ve got a problem in the economy. And the idea of spending a whole lot of money that you don’t have, like $787 billion, it never worked for him. And all of these nice predictions that we saw show that it just hasn’t worked the way the administration said that’s where we’re going to be. Here’s where we are. You see the trend of that line? That’s not exactly a hopeful trend.

I’d yield to my friend. Mr. SCALISE. I thank my friend from Missouri for pointing that out. And when you go back to those comments by Henry Morgenthau, the Treasury Secretary for FDR, the communist who Darwin is, there’s an old saying: history repeats itself. And the unfortunate part of that is we’re standing at a very critical point in our Nation’s history. We’re at one of those crossroads. And are we actually going to be here in Congress and try to perpetuate the great legacy of America, and that is that every generation has inherited a better Nation than the one that was passed down to them by the previous generation.

And that is a great tradition our country has always enjoyed. And that tradition is at risk right now. It’s at risk because of the spending and the borrowing that’s being perpetrated by the liberals that are running Congress right now.

When you show that comment from FDR, it’s very telling because when this administration came in, President Obama made a point everywhere he went that he was building on what Jimmy Carter created that ultimately led us to Ronald Reagan. When Jimmy Carter was President we had double-digit unemployment, we had double-digit interest rates, and double-digit inflation. In fact, they created a new term for it called “stagflation.”

When President Obama came into office, we were less than 8 percent unemployment. So it was single digit. It was still a high number, but it was a single digit. That’s when we had the stimulus. Right now, because of President Obama’s policies, these policies like cap-and-trade, like the spending and the stimulus bill and the health care government takeover, they have led us now to double-digit unemployment; but what we’re starting to see are the telltale signs also of creeping up interest rates and inflation because of the policies of President Obama.

So when he talks about this being the worst economy since the Great Depression, I think what he was trying to do was set up an event so that he knew his policies probably would create double-digit unemployment and double-digit inflation and double-digit interest rates, because history does repeat itself. So he tried to set the stage that he was walking into something worse than what he walked into, but he’s creating an economy that virtually is leading us back to the 1930s, when we did have an economy that was a Great Depression and the signs there, because of his policies that are spending, taxing, and borrowing our country into oblivion.

I yield back.

Mr. AKIN. Just reclaiming my time, the fact is that history does not have to repeat itself. It repeats itself if people make the same dumb mistakes over and over again. That’s what happened with Great Depression. They were much worse than the signs he inherited. The signs he inherited weren’t as bad as what Jimmy Carter created that ultimately led us to Ronald Reagan. When Jimmy Carter was President we had double-digit unemployment, we had double-digit interest rates, and double-digit inflation. In fact, they created a new term for it called “stagflation.”

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our citizens, are jobs. We know that we are in dire straits with jobs in this country, the first time in decades the unemployment rate has gone over double digits, at 10.2 percent.

Now looking back, I see my good friend has a chart there that talks about the stimulus and talks about the percentage of unemployed. I remember vividly sitting in this Chamber when we were talking about—and it was a mandate that we had to do something because unemployment was at 8 percent, and if we did nothing, perhaps it would go over 8.5 percent. What was done and what the Democratic Party did was to just spend, and I think misspend.

I believed in my heart back then that it was not the right thing to do, that, frankly, it would make matters worse, that it would drive up unemployment, because as people would lose confidence, those entrepreneurs, those people that are small business people, those folks who were willing to take that risk and work long days—sometimes without taking a salary themselves—to create prosperity—weren't going to have the confidence to be able to do that.

Usually I like being right. But unfortunately, I'm sad to say that we were correct, that I was correct, when unemployment went to 10.2 percent.

Mr. AKIN. Just reclaiming my time, gentleman, you were here on the floor with me when we were talking about this very thing. It wasn't so many months ago. It isn't that we are great wizards of economics. It's just that we've learned something from history. The fact is that the method and the approach of "stimulating the economy" or, effectively, tremendous levels of government spending and money that they don't have, does not help an economy that's ailing, and it's not going to help unemployment. We were here at this 8 percent unemployment, and we were told that, Hey, if you don't get this stimulus bill through, why, it's going to go above 8 percent. We passed the stimulus bill, and here we are at 10.2 percent. But that's not a coincidence.

Now of course the Obama administration would love to try to blame that on President Bush and everything. But what we didn't get learned from—even if he didn't want to learn from a Republican, he could learn from a Democrat. He could go back to JFK. JFK was faced with this problem. He had a problem with unemployment. And what did he do? He did something that was not intuitive to Democrats. He actually lowered taxes. He did a tax reduction just the same way Ronald Reagan did.

And the effect of that tax reduction was to allow that small businessmen to have more money to invest in their business. And guess what happens? When small businessmen have the liquidity and they have more money to invest in their business, they add a wing on the building, they add a new machine, a new process, a new invention, a new idea. And freedom works. What happens is, you create jobs, and the economy takes off.

Now here are some numbers that—to my good friend, Congressman Thompson from Pennsylvania, you weren't here at the time. But when I came in at the beginning of 2001, people don't realize—just because the Federal Government doesn't have the money to balance their budget—they don't like to realize how much these recessions and a bad economy hurts the Federal Government in terms of taxation, in terms of revenue.

And what was going on was, you know, the liberals were crying and moaning about how much money we spent on tax reduction, and Oh, we're giving the rich guys a deal, and you're reducing taxes, and that's going to cost the Federal Government all its revenue, because they calculated that if you lower taxes, you're going to collect less revenue. That was the logic. It seems intuitive when you just look at it superficially. But what you found was—and this was an interesting number—as we reduce taxes, the businesses, the small businesses, then created more jobs because they had money to spend. They created more jobs, and the economy turns around. What happens is, we take in more revenue than we had before. But let me show you. It is, in the most pessimistic sense, what surprised me was this: If you added the cost of—supposedly the cost of the Bush tax cuts, and you added the cost of the wars in Iraq and Afghanistan together, that total dollar value was less than what we had lost by the recession and what the recession had cost the Federal Government in revenue. You see this, gentleman, in Pennsylvania—and we do in Missouri, all the other States around the Union, that their balanced budget amendments—and that is, when the recession comes, boy, the States are hurting. They have to really scramble because their revenues drop dramatically when we enter a recession. But that's also true of the Federal Government. Our revenues drop tremendously.

So this formula of excessive government spending is the exact wrong thing to do. And what it does is, it turns a recession into a depression. That's why these charts are going the way they are. This should be a warning sign that what we should not be doing is a whole lot more taxing on small business, yet it seems that every time you turn around, here comes another tax. We've got to hit somebody, so why not tax?

Let's take a look at just one other thing, and this will be something I would like to get your impression on because Pennsylvania is a good industrial State. You've got a lot of jobs, a lot of good hardworking people there. It's kind of a theoretical question. But does the government really create jobs? You know, on the surface, it seems like if the government takes the money and hires somebody to build a building or something, it seems like they have created a job, because somebody's got to build the building, and they took some money, and they paid somebody, and the somebody did something.

So can the government really create jobs? What we find is that you've got to be careful. I just wanted you to talk about that a little bit, if you would like to, Congressman Thompson of Pennsylvania. I would, and I appreciate that opportunity. The government cannot create jobs. Unemployment is now 10.2 percent. I would admit that I'm sure within that, even despite the bad unemployment, there are jobs that are temporarily subsidized by the Federal Government, even some of the projects that I originally thought would be good stimulus infrastructure projects. Well, those are not sustainable jobs. Those are jobs only if the Federal Government is subsidizing them. As soon as that subsidy goes away, as soon as the stimulus money is spent, those folks are laid off.

A job, as I define it, is a good family-sustaining job. If you have there, that grows, that not only grows but that is working in a business, mostly small businesses is my experience, that is creating other new jobs. So this really has been fiscally irresponsible in terms of employment. It hasn't gone on for the right reasons. I think you and I are both supporters of a better plan. Now this is going back to when we were debating the stimulus originally, and the Republican alternative we had recognized that the true economic engine of this country is small businesses.

Mr. AKIN. Right.

Mr. THOMPSON of Pennsylvania. We had proposals that were put on the table, and you would provide tax deductions of up to 20 percent for small businesses, benefits that went to businesses with 500 employees or less, which effectively employ a large majority of Americans throughout the State. They are economic engines that create prosperity, create new jobs and not jobs that will go away when government subsidies stop. These are jobs that are sustainable because they are based on real economics. They are employing people that are hard working Americans. These are small businesses owned by individuals who are willing to make the sacrifices, take the risks to go after that.

Now as I travel around my district right now, I've talked with a number of people that I consider my heroes in terms of small businessmen and -women, people who have started with nothing, but they're willing to work hard to take that risk, and they had that American dream.

Mr. AKIN. Put everything on the line.

Mr. THOMPSON of Pennsylvania. Absolutely. And year after year, these
folks have been the ones that have gone out, and they’ve created new jobs every year by taking what they’ve invested, the return on their investment, and put it back into their small business. They reinvest there.

And that’s what I can’t believe how many of them I’m talking with right now that are sitting on the sidelines because they’re afraid of what’s been going on in this country since January. They’re afraid of the deficit spending they’ve seen. They’re afraid of the regulations we’ve seen. These are small businessmen that—most of them pay their taxes as a limited liability corporation or an S corporation. So they pay their taxes on their businesses through their personal income tax. These are the folks that my friends on the Democratic side of the aisle have been piling on in terms of new taxes, more taxes, claiming these are the rich, and they can afford to pay more taxes. Well, actually what these are are allors, and when they pile on them, it forces them to sit on the sidelines.

Mr. AKIN. Just reclaiming my time, what you’re talking about is the old proverb of killing the goose that lays a golden egg. The thing is, the thing is, it’s a little bit tricky, because if you think about it, the government goes to hire somebody to build a highway. You say, Well, that’s a good job. Somebody is building a highway. Well, it’s true that for some period of time. And you put the emphasis on temporary—that job is there as long as we are taxing somebody to get the money in order to hire that guy. The way that economics works is that for every job, by taking taxpayers’ money and creating a job with the government, what we do is we kill 2.2 jobs in the private sector.

So effectively, what you’re doing is a very inefficient means of bleeding part of the sector that creates the real jobs and currently a temporary government job. My son is in Afghanistan. We have places where the Federal Government hires people. They’re legitimate jobs that need to be done, but all of those things are balanced on the back of the private sector. If you get too greedy and you start to squeeze the private sector enough, not only do you make it sick, you can kill it. And that’s what was done during the Great Depression. They started taxing those small businesses put so many regulations on them that they killed them, and they went out of business.

And that’s what’s starting to happen, and that’s what frightens me terribly about the approach that we’ve got here. As I started this evening, I talked about what are the things that destroy jobs, and you just intuitively—you are talking about the people of Pennsylvania and about the businesspeople, you know, those courageous, quiet souls that go out and take the risks, not knowing otherwise they’re going to end up sleeping under a park bench if their business goes out. They’ve put their whole life into it. They’ve invested in a new piece of equipment. And in the process, they create wealth and create jobs and stuff, those people. Well, what do we do if you really want to hurt them? Well, what we do is we’ve been doing for the last year, eradicating out-of-control Federal spending on all kinds of wasteful things. For instance, that stimulus bill had billions of dollars for community organizers like ACORN. We had money in that bill to produce that Web site that created congressional districts that don’t even exist, claiming the jobs were created. That’s a waste of money. The next thing, as you properly pointed out, is that you start taxing people, not only for the stimulus bill, but you tax them on energy.

So now this guy that’s got a business, perhaps he uses a fair amount of energy, thinks, uh-oh, I’m going to have taxes on energy now. Then the issue that you properly pointed out is that you start creating this sense of fear among the small businessmen. And you’ve got red tape and more taxes and more taxes. The guy thinks, How in the world am I going to make a living with that? That’s what’s being done not just in Missouri and Pennsylvania, but it’s being done because we’re doing the wrong things. And it’s not so complicated because other Presidents have shown the right way to go.

Let’s just take a look at what we’re doing just for the fossil fuels. You started to list them off. First of all, there’s the death tax, and there’re dividends and capital gains. Those are taxes that were cut by Bush back in 2001 and ’03 in order to get those small businessman up and going. So those have been cut temporarily, and now that’s going to expire, and what have the Democrats told us? I yield.

Mr. THOMPSON of Pennsylvania. I think this week, tomorrow we’re going to be voting on the estate tax here. Mr. AKIN. Death tax.

Mr. THOMPSON of Pennsylvania. The death tax.

Mr. AKIN. Death is a taxable event, is the way they want it to be.

Mr. THOMPSON of Pennsylvania. It’s not only a taxable event, but it’s doubling taxation because all the money the government will be taxing has already been taxed at one time or another.

Mr. AKIN. So we’ll get them coming and get them going. If they’re dead, they don’t complain as much.

Mr. THOMPSON of Pennsylvania. I think that’s an excellent point, but that still doesn’t make it right, and it’s just absolutely wrong. I think the rate that we’re looking at was 45 percent.

Mr. AKIN. Okay. So let’s just run this logic. How logical is this if you want a decent economy? A guy is a farmer. Let’s say he’s got 200 acres of ground, maybe it’s 300 acres of ground, and some tractors, and he dies. Now his son wanted to run the farm. So now when he dies, what does the son have to do?

Mr. THOMPSON of Pennsylvania. He’s got to sell part of the farm because there is certainly no large fortune in farming sitting back there in liquid assets to be able to pay the death tax.

Mr. AKIN. So he has got to pay 45 percent of the value of the farm. If he’s got 2,000 acres and a couple of tractors or whatever it is, he will have to sell almost half of that. Then it will get to the point where the farm is no longer sold half of what it is so that it doesn’t really work. So what happens then?

Mr. THOMPSON of Pennsylvania. Well, I can’t imagine. And today farms is such a challenge. We just had a hearing earlier today with one of the Agriculture subcommittees on the impact of the climate change on farmers. I was relating the plight of the average dairy farmer in my district. Dairy farming is a big industry. It’s certainly an important industry to our Nation. Farms range in sizes, but the average size of a farm in my district is about 80 head of cow, 80 to 85. They tend to have enough acreage just to grow their own corn, to grow their own feed. Beyond that, that’s the operation they’re run.

And today on a dairy farm—and this is a Nationwide statistic—because of the problems we have with the pricing of milk, the fact that the Federal Government got involved in that decades ago, the average farmer loses $100 per cow per month.

Obviously, when, unfortunately, a dairy farmer passes away, there is no reserve sitting there to pay off the death tax. What are you going to sell from a dairy farm to pay that tax? Are you going to sell the cows? Well, you’re not going to be a dairy farmer. Are you going to sell off the acreage? You’re not going to be a dairy farmer. Are you going to sell the place? You don’t do that. You need the tractor. I think that just represents the plight of our farmers with that type of tax. There is nowhere to go.

Mr. AKIN. Reclaiming my time, it’s interesting you mention that. I have a nephew that worked on a dairy farm in upper New York State. What you mentioned, 80 cow. The number I recall then was about 90 cows, 90 to 100 cows. It’s kind of the standard lot size. It’s about how much one man can kind of operate with his family.

So if you all of a sudden have to sell half of that, even if you could—say you could sell half the cows, half the farm, half the equipment, the problem is that half of it doesn’t work. It no longer works. So if with every generation, you’ve got to cut the business in half, and give half to the Federal Government, how in the world are we going to have jobs and a strong economy? It’s just nuts.
had a couple years ago when we put it in place and it helped the economy get going.

Then on top of that, we've just spent $787 billion on that silly stimulus bill, $700 billion for the Wall Street bailout. And believe it or not, the biggest tax increase in the history of the country for global warming, an energy tax, along with tons of redtape that goes along with it, telling everybody in the country they've got to have an electrical outlet in their garage for their golf cart or whatever it is.

I mean, this is an awful lot of redtape, regulations, and taxes, all with the effect it's going to just kill those jobs. So there's a reason why that red line is going up, isn't there?

Mr. THOMPSON of Pennsylvania. If the gentleman would yield.

Mr. AKIN. I yield.

Mr. THOMPSON of Pennsylvania. Certainly, we cannot forget the taxes from the health care bill.

So on top of all of this, the redtape, the uncertainty, the lousy economy, tax after tax, now we're going to hit them and tell them, by the way, any employee you've got, you're going to have to pay for their health care and we're going to tax you heavily for that. What's that going to make a small business man do?

I yield.

Mr. THOMPSON of Pennsylvania. That's a great point.

There was a headline in The Wall Street Journal just yesterday that said “Job Looms as Stimulus Fades.” And I think that speaks to the original point that we've made that the stimulus is unsuccessful. It has failed.

I know the President is having a jobs summit tomorrow. I'm hoping, actually praying, that when he does that, that better minds prevail and he hears from people attending that summit the types of things that we've been talking about. And we have been talking about this since January because we know we've had this issue. We have been talking about both things such as cutting taxes for small businesses, of reducing the burdens that we put on those job creators. I mean, those are the types of things that we should be doing in terms of economic stimulus. And I know that our friends, the Democratic colleagues, are going to be looking at a stimulus two here, and my concern, my big fear is it's going to another special interest, big spending bill that really isn't about any jobs, but it will be in the name of jobs.

Mr. AKIN. Reclaiming my time. I appreciated your optimism. The President has declared that he's going to have a meeting to get together and talk about the economy and everything, but I happen to know something about the invitation list. I don't know who was invited, but I have a pretty good idea.

I know who was not invited. The U.S. Chamber of Commerce. They represent businesses and small business. They weren't invited. The National Federation of Independent Business. These are all over. I assume you have them in Pennsylvania.

Mr. THOMPSON of Pennsylvania. Oh, yes.

Mr. AKIN. I have them in Missouri. These are coalitions of lots and lots of small businesses. You think they were invited? No, they're not invited. Who is invited? All the people who got money under the first stimulus bill.

So, first of all, the whole idea of the stimulus bill is wrong economics. You're not going to get the economy going by spending more money. If getting the economy going by spending money were how you did it, holy smokes, our economy would be red hot and on fire. We've been spending money like there's no tomorrow. And the economy is not doing so well. Look at that unemployment line. Spending money is not the solution. Yet the idea of more stimulus, more stimulus, it's insanity? We're getting close.

I yield.

Mr. THOMPSON of Pennsylvania. There's a two-part penalty to this. One is that we're spending all this money, but this is not even money that we have. This is deficit spending. This is spending that we have to reach out to creditors and to take out loans. And who is our number one creditor? Who's the number one entity that's lending the economy money by not just spending; it's deficit spending.

The last time I remember a situation like this specifically was back at the tail end of the President Carter years, and my wife and I were young. We had just married. We were looking to purchase that first home. And we weren't making a whole lot of money, but it looked like, actually, as we looked around, that real estate wasn't particularly very expensive, and the reason for this was because of the inflation and stagnation that was going on at that point in time. So we actually applied for a first-time homeowner's loan from the State, and we thought we were in the money. We got that, and our interest rate was 14 percent.

Mr. AKIN. Fourteen percent.

Mr. THOMPSON of Pennsylvania. Fourteen percent. But that was a great interest rate, because at that point, I believe it was running at 19 and 20 percent. It was because of where we were in terms of high inflation and high unemployment, stagflation.

Mr. AKIN. Of course. The inflation is created by the Federal Government basically dumping more and more money into the money supply.

Mr. THOMPSON of Pennsylvania. Absolutely.

Mr. AKIN. I was just looking at a chart from 1960 up through this year, and you go along and it looks like a little saw tooth. It's running along. It's called M1, or the money supply, and last year we had a 10-times' increase in the government's release of that liquid and-tax and the health care. To estimate that as a trillion is being generous.

I think it's helpful to compare a couple of things that are similar. As you recall, the Democrats were critical that Bush spent too much money. In fact, I was here some of those years. I voted against some things that the administration wanted because I thought it was too expensive. But let's take President Bush's biggest spending year, his biggest deficit was in 2008. That's when the Democrats ran the House here. That was about $450 billion or so, and that was 2008. If you took the $450 billion as a percent of our gross domestic product, that was about 3.3 percent. This year they just calculated the numbers, and the spending is $1.4 trillion. That's three times more spending in the first year than President Bush's was in his worst year out of 8 years, three times more. And it puts the level of debt that we have created not at 3.3 percent of GDP but at 9.9. So we're more than tripled that ratio. It's the highest it's been since World War II because of this, because we just can't seem to say no to spending. And that's not the formula to help with the jobs problem.

I yield.

Mr. THOMPSON of Pennsylvania. It's almost like our Democratic colleagues look at it as a candy store and that there's no end to it. It's an endless supply. And I suspect that at some point where—I know that we're probably coming up on the debt ceiling in terms of the amount of debt that we're able
and allowed by law, by statute, to accumulate as a country. And I don’t know that exact total, but I believe it’s somewhere around $14 trillion, and the fact is that we are fast approaching that just after this past year.

I came here in January. Frankly, I think that was financially irresponsible in years past. I would be the first to admit that in terms of my party. And that’s one of the reasons I was motivated to come, because if we were running a household, we would not be responsible. We would be bringing that debt down. We need to be working towards being debt free. That is fiscal responsibility. That is running this House the way we run our houses at home, and that is something that we need to restore. We have not had that for a very long time in this country, but I think that is something that we need to be committed to.

Mr. AKIN. You’re absolutely right. The reason that we’re getting off the wrong track here is just because of this whole liberal Democrat concept of economics. They’re trying to make two plus two equal five. They’re trying to basically repeal the law of economics.

If you and I in our household, if we thought, oh, we’re getting tight on money, we’re starting to have economic hard times in our family, so let’s go out and just run up a huge credit card bill and that will somehow make it better, people would lock us up. They’d put us in little white suits and lock us away somewhere and say these people are crazy.

Mr. THOMPSON of Pennsylvania. And we did that. Unfortunately, that does happen in our Nation, and what happens is people experience bankruptcy. They ruin their lives by doing that.

Mr. AKIN. Right. Except in this case, when the Federal Government does it, we bankrupt the entire Nation.

Mr. THOMPSON of Pennsylvania. Correct.

Mr. AKIN. And one of the effects of the bankruptcy is unemployment, among other things, but it also is impoverishing everybody.

You can’t repeal the basic laws of supply and demand, and you cannot basically give away housing where people can’t afford to pay for it without expecting to have consequences. Kind of going back to the beginning of things, that’s what got us into this trouble not so many years ago.

Here’s something I think a lot of people aren’t aware of but we need to understand, how did we get into this problem? It was because of this idea that somehow we think that we are able to repeal the laws of economics. This is September 11. It’s not 2001. This is September 11, 2003. It’s an article in The New York Times, not exactly a conservative source of information. And this article appeared in the same edition of the same paper, and it says: “The Bush administration today recommended the most significant regulatory overhaul in the housing finance industry since the savings and loan crisis a decade ago.”

Let’s talk about what this was. This is The New York Times. This is bad President Bush’s saying that we need to have a significant regulatory overhaul in housing finance and the strongest thing since the savings and loan crisis.

“Under the plan disclosed at a congressional hearing today, a new agency would be created within the Treasury Department to assume supervision of Fannie Mae and Freddie Mac, the government-sponsored companies that are the two largest in the mortgage lending industry.

So this is 2003. Bush sees irregularities in Freddie and Fannie in how they’re managing the business. Why would there be irregularities? Because they were mandated and allowed to make loans to people who couldn’t afford to pay the loans.

What’s the Democrat response to what President Bush wanted to do? Well, what happened was he passed a bill in the House to do this. I was here. We voted for this bill. It went to the Senate. It was killed by the Democrats in the Senate.

What was the Democrat response in the House to Bush’s saying we’ve got to get on this Freddie-Fannie problem or we’re going to have an economic crisis on our hands? Well, with respect to Fannie and Freddie, I did not want the same kind of focus on safety and soundness that we have in——

The SPEAKER pro tempore. The gentleman’s time has expired.

Mr. AKIN. Mr. Speaker, for joining me. It seems like the time has flown, and I look forward to our next evening.

THIRTY-SOMETHING WORKING GROUP

The SPEAKER pro tempore. Under the Speaker’s announced policy of January 6, 2009, the gentleman from Ohio (Mr. RYAN) is recognized for 60 minutes as the designee of the majority leader.

Mr. RYAN of Ohio. Mr. Speaker, we’re happy this afternoon to introduce another edition of the 30-Something Working Group in which we will try to bring some facts and some analysis to the floor of the House of Representatives.

I can’t help but get up after having to sit through what our friends on the other side were saying about the economy, push globalization, not enforce our trade laws—all with a rubber stamp from the Republican Congress.

And then all of a sudden in 2008, the bottom falls out. Wall Street collapses. We see the stock market collapse, credit locks up. On and on and on. And our friends on the other side act like that just happened by happenstance.

So I bring to you, in order to try to address those issues, we have to make some very difficult decisions as a country and come together as a country. And we get people ignoring the previous 8 years, when anybody who is being realistic can see how we got here.

And all we want to do now is have a conversation about how we move forward and how we use this and see this as an opportunity to address some of the major structural changes that we have in the United States of America. And there are two major ones in our economy that have been like an albatross around the necks of small business people all over our country and big businesses all over our country, and that is health care and that is energy.

And so this Congress has stepped up to bat to address two of those major problems without a lick of help from the Republicans, not a lick of help. And at the end of the day, they’re going to lose the wrong side of history, like they were for Social Security and Medicare and civil rights and a lot of the other major issues that really gave us things to be proud of in this country.

And so as we move forward with the House bill on health care—and now the Senate is opening up debate and having debate on the health care bill—we are trying to address the concerns of the American people.

I want everyone, Mr. Speaker, to understand the issues that we have taken up here as a Democratic Congress. And this is all with the understanding that we know that the unemployment rate is too high, there is too many people out of work. There is a lot more work to be done.

But if you look at the previous 8 years prior to President Obama, you will see an administration that completely catered to Wall Street and Big Business in the United States of America—(erroneous administration, whether it was immigration laws, whether it was health care, whether it was energy. You could bet your bottom
dollars that President Bush was on the side of Big Insurance, Big Pharmaceutical, Big Oil, Big Agricultural, right down the line.

And when we came in as Democrats, we began to change that. And all you have to do is—what they say you can judge someone by their friends—is what you are. And the Democratic Party took on the oil industry.

The Democratic Party is the party getting the banks out of the student loan business, the banks that are at hand. And here are the facts: if we do absolutely nothing with health care, the average family of four next year will have an $1,800 increase, $1,800. And then the following year it will be another $1,800. And then in another year, another $1,800. That’s reality. Everyone is agreeing on that.

If we do nothing, human beings, American citizens in this country, will continue to get denied coverage by insurance companies because they have a preexisting condition. That preexisting condition could be you were involved in a domestic violence situation; that preexisting condition could be infertility, or as we even heard, spousal infertility. You’re denied. Diabetes, Cancer. That’s if we do nothing. If we do nothing, just in my congressional district in northeast Ohio we will have 1,700 families go bankrupt next year because of health care costs—if we do nothing. And on and on and right down the line. An inhumane, costly, expensive, inefficient health care system.

And so we chose to take on the big fight. We chose to make a human decision to say this problem needs to be fixed, it needs to be addressed, and we know it’s politically risky but we know we’re going to do it because there are too many people in the country, Mr. Speaker, who need us to act and not sit on the sidelines where it is safe.

It turns out we could have just said, You know what? We’re going to play it safe. We’re not going to do anything that’s going to upset anybody or get FOX News riled up or Rush Limbaugh or Clear Channel, the right wing talk radio. We’re just going to play it safe. But at the end of the day, history would not be very good to us because they would have said, What did they do in Washington, D.C., when this decision, these hard decisions needed to be made 10 years ago?

And our kids and our grandkids would say, Jeez, Mom. Jeez, Dad, you were in Congress during the very difficult time. We needed some big decisions to be made. What did you do when you were there? And you can look proudly at your kids and say to them, I did nothing. I played it safe. I sat on my hands because I wanted to get re-elected or I was afraid that Rush Limbaugh would make fun of me.

The reforms that are coming out of this House of Representatives—as I have said when I am back home in Youngstown, Ohio; in Niles, Ohio; in Warren, Ohio; in Ravenna; in Kent and Portage County; Akron—these reforms are going to help people who have struggled and fought and got zero wage increases over the last 30 years, who’ve got haggled with the insurance company, get denied, get ignored while they’re on their death bed, lose their job, lose their pension. That is wrong, Mr. Speaker. Wrong. And we’re going to do something about it.

So let’s just take what happens when health care reform passes. There will be some time until the exchange gets set up, and you know, whether there’s a public option and what it looks like. That may take a couple of years. But immediately what happens is that no longer in America will you get denied coverage because of a preexisting condition. And we will see a woman who’s pregnant, or a son or daughter, who is under the age of 27 years old, they can stay on your health care insurance. So all of those young people in their early and mid-20s who can’t get health insurance or can’t afford health insurance can stay on their parents’ health insurance. That gets implemented immediately.

If you have a health care catastrophe in your family—and being a Member of Congress, we get these calls, and we are out in the public and we meet these people at the fairs, at the festivals, at the bowling alley, at the bingo halls, at the civic events—there will be a cap on how much you can pay out of pocket per year on health care costs so that you don’t go under. The United States of America is going bankrupt because they had a health care catastrophe. And all of our friends on the other side of the aisle who talk about family values and everything else voted against that. Voted against it.

So when you look at the health care reform bill, it is a values issue. It is a family values issue that we need to address. And our budgets and our investments speak to that, speak to our values and what we care about and what we stand for.

And when you look at it, AARP’s endorsed it, the American Medical Association’s endorsed it, the Catholic Bishops had nothing but good things to say about it. And even the Business Roundtable, the top CEOs in the country, said that the health care reform bill in 2019 will save them, $3,000 an employee, $3,000.

Now, you can argue with me, you can argue, and call people coming out of the socialist parade and call all of us the names that our friends on the other side have been using for the last 60 or 70 years in their rebuttals to policy initiatives by the Democratic Party, but you can’t argue with the Business Roundtable saying that it’s going to save them $3,000 per employee.

And aren’t we tired of getting calls from small business people telling us about all of the increases, all of the rate increases? And you talk about all the other day from a health care provider talking about this issue and another from a health care business person who said he just got in the mail a 50 percent increase for his business. He had one employee. One hundred, hundred get sick. Pushed the number up. Next thing you know, he goes from paying $600,000 a year to next year he is going to have to pay a million dollars a year. And he said, Timmy, I may have to shut the doors. That’s what we’re trying to prevent.

How can we have any sustained long-term economic growth if we don’t take care of the health care issue in this country? If we keep strangling our small business people? And I understand that there may be some small business people that maybe disagree with any extension of the role of government in any area. But there is nothing left to understand that this insurance industry and the extreme right of the Republican Party, the neoconservatives, continue to be offended. Nobody here wants to hurt anybody. Nobody here wants to destroy America. We are here to help, and we are here to address these problems collectively as a country.

We have people on the other side of the aisle, because Rush Limbaugh says they shouldn’t, they won’t even work with us. Getting rid of preexisting conditions, letting people be on their parents’ insurance until they are 27, limiting how much out-of-pocket you can spend, making sure that they can’t knock you off the rolls after you have cancer, insurance coverage, these are some basic things that we should all be able to agree upon. Mr. Speaker, we are doing it.

And the same issue happens with energy, to where we send in this country $750 billion a year in wealth out of our country through the gas stations that go to oil-producing countries: a $750 billion wealth transfer right out of our country. And a couple of years ago, Mr. Speaker, we spent about $15 billion out of the Defense Department that Exxon Mobil and Big Oil ships in and out of the Persian Gulf. So if you do the math, the Persian Gulf oil that ends up in your gas tank should really
be $1.50 more because of the subsidies that the American taxpayer has paid to provide the security of these ships going in and out of the Persian Gulf. Now in addition to that, subsidies for oil companies, tax credits and tax cuts to go and continue to drill, so completely subsidizing Big Oil and the oil economy.

And what Democrats have said is, how do we put together an energy policy that will take some of the $750 billion in oil we are letting flow onshore and offshore, how do we direct it back into the United States, and at the same time reduce CO2 and at the same time resuscitate manufacturing in the United States of America through our windmills, through our solar panels, using natural gas that is here in the United States.

We don’t have the kind of oil that some of these other countries do. And why do we prop up these dictators and these royal families who have no concern for the workers, who can use the need for energy and make it work for us and put together a system and a national policy that is pro-American.

There is not a bigger, more patriotic piece of legislation in the United States of America’s House of Representatives right now than the energy bill that passed this House. What kind of national security plan is it for us to continue to send money that goes to these kinds of fund terrorist organizations that don’t like us when we could be putting steel workers to work making the 400 tons of steel that go in the windmills or resuscitate manufacturing in the United States of America by making sure that our people manufacture the 8,000 component parts that go into a windmill. To me that makes a good deal of sense.

And both of these issues in the long term are jobs programs. Does anybody have a better job for Mr. Speaker than how to stimulate manufacturing in the United States? I can’t think of one. We have tried to cut taxes on the top 1 percent and hope something trickles down, and that means they will invest back in America and will create jobs in the United States. That didn’t work. It did not work. The Republicans had the House, the Senate, the White House. They implemented the whole George Bush economic policy, and it didn’t work, and here we are today.

I know our friends like to be critical of the stimulus bill, but in January we lost 750,000 jobs. Now we are still losing a couple hundred thousand jobs a month, but it is not quite as bad. We are trending in the right direction, and we do need to put together a jobs program. We do need to invest in the transportation and put thousands and thousands of people to work. We need to do that. We need to make those investments. There is no question about it. And get back to a moderate, balanced, prudent, wise, economic policy and tax policy here in the United States.

The old Keynesian economic theory that asked some of the wealthiest people in our country to pay a little more in the good times, cut taxes in the bad times and increase social spending to stimulate the economy and smooth out these rough edges, worked for a long time in the 1950s to the construction of a great middle class, balanced investments in education and transportation and roads and bridges.

It is time for us to get back to that. And in the 17th Congressional District we are putting together what is a very smart, balanced, economic policy locally where we are making the proper investments and laying the proper groundwork. What we are trying to do locally is to line up with where the national policy and the national trends are going. You had to be sleeping if you can’t tell that the world is moving towards green technology, green energy. The hedge funds, the big money people are all there. Moving the scientists, the engineers, all moving in that direction. All of the research moving in that direction.

And so there is health care reform and what that will do for our local manufacturing economy. And so we have been fairly fortunate amidst all of the economic problems and the high unemployment, that we are seeing back home seeds that are beginning to sprout, and that once credit loosens up, we will see long-term economic growth.

But we need our national policies, Mr. Speaker, to shape us as a country and push our economy in the right direction. The big decisions that are being made here through the Obama administration are sound. I think we are making some smart long-term decisions, and it will pay off in the long run.

We see it in sports all of the time where a team may come in and start to build your program, whether it is college football or basketball or the NBA or whatever the case may be, where you see a great coach start to implement the plan and you don’t necessarily start winning all of the games right away. You saw it with Bill Walsh in San Francisco, and you see it with the Patriots and the Steelers. It doesn’t always start off with the Super Bowl. And for the Browns, Mr. Speaker, it has been a rough road, but we are going to get back to a difficult time to have been a Cleveland Browns fan. But the bottom line here is we are in a rebuilding process. We are laying the groundwork. We are making the fundamental decisions necessary to allow for long-term economic growth.

When you look at health care and 30 million more people that are going to have health insurance, we are going to need docs, we are going to need nurses. There is going to be a total reinvigoration of health care information technology.

Just, for example, I was at the National College a few days ago in Youngstown, Ohio. They have programs primarily in health, health information technology and some business entrepreneur classes. The college opened up with 50 people. It now has 850 kids from Youngstown and Campbell and Struthers and Warren going to this college, to learn health information technology.

Now here we have people, young and middle-aged, looking at where the economy is going and what they need in the future. And investment in health information technology in the stimulus bill, the investment that we will be making in health care by making sure that everybody is covered and coordinating all of these different systems, is going to be an opportunity for many of these young kids who are doing what we asked them to do: Go to school and get educated and do the right thing, and you will be rewarded.

And so in 10 years, Mr. Speaker, in 2019, 2020, we will look back on these decisions that have been made in this Congress and we will see that we have eliminated a lot of human suffering because of what we have done with the health care system. We will see that we have reined in costs for the insurance companies, and that has allowed small businesses to reinvest back into their own companies and give pay increases to their workers as opposed to covering all of the health care increases. We will see what a compassionate government can exist to advocate on their behalf.

A lot of people say, I am afraid of the government. It is not the government you need to be afraid of; it is the big insurance company you need to be afraid of. It is the Big Oil companies you need to be afraid of. And we are taking them on. Ten years from now, it is going to be looked back upon as one of the turning points in our Nation’s history, like Medicare, civil rights, and like a lot of the great programs that have been established to help our people. Average Americans are getting represented in this government.

We will look back on our energy policies, and we will see that we have reduced our dependency on foreign oil. We have given people hope. We have re-established America as an innovative leader in the world, and it will help our health care reform and lift up the middle class because we need to start making things again in the United States. We need to start making things again. And with windmills and wind turbines, these are things we can’t ship in from China. We have to make them here. We are, and it is going to put middle class people back to work. So those two major issues are going to unleash the creativity needed, the American spirit needed, the American independence needed.

I am proud of what is happening here. I am proud of what is happening in the United States. I know it is difficult. I know it is tough. I know it is noisy.
Mr. Speaker, but these things are happening for us in the United States. When it is all said and done and that parent goes to get health insurance, or some young person goes to get health insurance, and they call the insurance company, and they have diabetes or cancer, the insurance company cannot deny them.

Their parents are going to say, Did you know there was a day 5 years ago where you would have gotten denied coverage? And 20 or 30 years from now, our kids will say, You've got to be kidding me. That really happened in America? And we look back on the civil rights movement today. Our generation says, You've got to be kidding me. White people and black people weren't allowed to drink out of the same water fountain?

That's how we're going to look back. Did we really as a country do that? And it is shameful that that happened in this country. Those are the same exact feelings and sentiments that we are going to have here in the United States years from now. And we will say, Did we really deny people health care? We really had people die because they couldn't afford health care when the treatment was available and the technology was available? We really let that happen?

This is a turning point in our country's history, and I'm proud to be a part of it.

HONORING THE GENEROSITY AND COMMUNITY SERVICE OF JERRY LONG

(Ms. FOXX asked and was given permission to address the House for 1 minute.)

Ms. FOXX, Mr. Speaker, I rise today to praise the generosity and community work of my friend, Jerry Long. Today, Jerry is being honored for his generous philanthropy back in North Carolina as the West Forsyth Family YMCA officially changes its name to the Jerry Long Family YMCA.

This honor comes to Jerry thanks to his tireless work as a community leader. He is someone who understands that making a positive difference in your community and helping your neighbors can start with the hard work and dedication of just one person.

His example of serving his community is inspiring, and this renaming is a much deserved honor. Congratulations to Jerry and his family, and thank you for your many years of giving back to Forsyth County and the communities there.

IMMIGRATION

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2009, the gentleman from Iowa (Mr. KING) is recognized for 60 minutes.

Mr. KING of Iowa. Mr. Speaker, I'm privileged and honored to be recognized to address you here on the floor of the House of Representatives, and I appreciate the opportunity to, I think, help enlighten you and the Members that are listening in and anyone who might be observing this process that we have in the House of Representatives.

In this body, there is a limited amount of time that we can debate here on the floor. And as things churn through, sometimes we don't come back and revisit subject matter, but think it's necessary to establish the perspective that fits into the broader picture.

The perspective that I intend to address tonight is the perspective of immigration, and that debate has gone on in this country for a number of years. It was brought up by Pat Buchanan as a candidate for President back in the 1990s. He said he would hold congressional hearings on immigration if he were elected President of the United States. He did a lot to help galvanize this immigrant issue and bring the issues that are important to this country to the forefront. And since that time, people like Tom Tancredo, and probably before that time, actually, came to this floor and raised the issue of immigration and the rule of law over and over again.

Eventually, the American people began to look at the circumstances of millions of people that are in the United States illegally, their impact on this economy, this society, and this culture.

As intense as this debate got in 2006 and 2007, it got so intense, Mr. Speaker, that as the Senate began to move on a comprehensive amnesty bill that was bipartisan in its nature, however weak it was in its rationale, it had the support of the President of the United States at that time, George W. Bush, and it had the support of leaders of the Democrat and the Republican Party in the United States Senate, and was considered here in the House of Representatives, Mr. Speaker. And yet the American people rejected the idea of amnesty in any form, whether it be comprehensive immigration that was proposed and then the nuances that they tried to bring through or whether it would just be blanket amnesty.

Well, here we are again, Mr. Speaker. Here we are again with a transformational issue that is slowly being brought before the American people, and I'm here to say, let's pay attention. My red flag is up, and I have watched the transition of issues that have unfolded since, actually for years, but intensively unfolded since the beginning of the Obama Presidency.

And these issues unfolded in this fashion, and perhaps I'll go back and revisit them in some more detail. But the American people did go to the polls a year ago last November and sustained majorities and actually expanded majorities for Democrats in the United States Senate and in here in the U.S. House of Representatives, and they elected a President who fit their mold as a party member, a Democrat, a very liberal Democrat. In fact, President Obama, in the short time that he served in the United States Senate, had the most liberal voting record out of all 100 U.S. Senators. So they elected, I think, it's not even arguable, the people in the United States elected the most liberal President in the history of this country.

And while there wasn't a legitimate debate in the Presidential race that had to do with immigration, because neither candidate really wanted to touch the issue, they knew that they were at odds with the American people on immigration. John McCain knew that, and he didn't bring up the subject after the nomination, at least not in a substantial way. I couldn't say that it never happened. And Barack Obama knew the same thing and didn't bring immigration up in a substantial way during the Presidential campaign after the nominations.

And so this Nation went forward with discussions about national security, about economic development, discussions about energy, but not discussions about immigration. Here we are today, a year and a month after President Obama was elected and we have seen these big issues come through this Congress. And here is the sequence of events, Mr. Speaker, that has taken place, and I invite anybody to challenge me on the facts of these, but it is this sequence:

During the Bush administration, we had the beginning of the first call for TARP funding. That was the beginning request that began by my mental marker here, chronologically, September 19, 2008, when Secretary of the Treasury at the time, Henry Paulson, came to this Capitol and asked for $700 billion. All of it, of course, would be borrowed money. All of it would have to be paid back, and the interest on it, and the taxpayers would have to pay for their children and their grandchildren, presuming we would be able to retire our national debt in that period of time. Or it might take more generations, Mr. Speaker. $700 billion in TARP, this Congress approved half of it then, and I believe that it was actually into October, the early part of October 2008, delayed the other half, the other $350 billion to be approved by a Congress to be elected later and signed into law by a President in nations, including Freddie Mac, AIG, the large insurance company, General Motors, Chrysler, all of that swept through in a period of
time of approximately 1 year. And at the tall end, framing the nationalization of those eight huge entities that represent about one-third of the private sector profits in the United States, framed on the other end of that nationalism effort on the part of the White House and then reported that, was a $787 billion economic stimulus plan. All of this just raced us towards the nationalization of an economy, the socialization of our economy. It was a mistake.

The American people looked at that, and it went so fast that they didn’t believe they had the expertise. They trusted Wall Street. They trusted Big Business in America, and they believed, as I did for a time in my adult life, that Wall Street was looking out for the foundations of free-enterprise capitalism so that over the long term they could continue to do business in a free-market environment to be able to buy, sell, trade, and make legitimate gains. Wealth is rooted in the productivity increase of the American workers and the American economy. Well, it didn’t turn out to be necessarily the case that clearly. But it's actually was unfolding, $700 billion in TARP, that eight huge national entities of the private sector that were nationalized by the Federal Government, and the $787 billion economic stimulus plan, all of that came at the American people faster than they could react and farther than they could understand. And they were not simple enough in the foundational understanding of them that the American people could look at that, describe it in a bumper sticker and mobilize. It took too long to explain. It was harder for the American people to get caught up, and it was hard for Members of Congress in the same fashion to understand the nuances and the details with the level of confidence necessary to rise up and say, Hold it. That’s it. We’ve got to stop. We cannot race down this path and leap off of the abyss into the socialized economy. But that is where we have gone. Mr. Speaker.

The American people started to catch up when they saw cap-and-trade being pushed through this Congress. The cap-and-tax legislation that taxes every bit of energy in America and transfers wealth from one group of people in America to another group upon whom they understood that. It came so fast they couldn’t get mobilized very much.

Meanwhile, while this was going on, organizations across America were spontaneously growing up out of the west coast, out of the mountains, out of the western States and off the east coast. People that love this Constitution, love fiscal responsibility and free-market capitalism have risen up, and they have carried their flags into city after city, and they have jammed the cap-and-trade legislature and the cap-and-trade United States Capitol. And when you look out across that sea of people, you will see represented there, Mr. Speaker, American flags, one after another after another, patriotic Americans, any one of which I would expect to see at my own church picnic. And among those American flags, you will see yellow “Don’t tread on me” flags. These are the Americans that that is also political power as well as an economic greed in this country.

All of that has taken place. The American people have mobilized. By the end of July of 2009, this year, they had seen all of this press, and they saw cap-and-trade, or cap-and-tax, pass off the floor of the House of Representatives and a hurry-up rush to judgment, a proposal and a model that cannot be sustained, debated, or argued in any logical fashion that has to do with economics, and neither can the science be defended, especially in light of the emails that have been dumped onto the Internet in the last week or two.

And we’ve seen at least one resignation, Phil Jones, one of the scientists promoting the climate change argument. The change actually went from the words “global warming” to the phrase “climate change,” because obviously they can’t show the warming of the globe over the last decade in the fashion that they predicted at least.

All of this happened and we saw town hall meetings fill up all across America during the month of August and early September. Hundreds and hundreds of town hall meetings. Hundreds of thousands of Americans came up and filled those town hall meetings, and they filled up the public squares, and they stepped up and resisted the idea of a government-run health care system of socialized medicine in America.

Now the American people are starting to get some traction. They see the pattern. They voted for change. They didn’t know what the change was, Madam Speaker. And now they have a pretty good handle of what has been in store for us, and they reject it. It’s why they filled up the Capital and filled up the town hall meetings.

But what we’ve seen so far is this intensity, this resistance to a national health care act, the resistance that brought somewhere between 20,000 and 60,000 people here to this Capital to be outside this west side of the Capitol on the Thursday before the final vote. And some of those people that came here on Thursday got on a plane and flew back to their hometown, landed, and they saw that they had a request to come back to the Capital to do this again on Saturday, to do our very level best to dump out all of our energy to kill this socialized medicine bill. #2015

That’s the American people mobilized, Madam Speaker. The American people have gone all of this country and they came to this city just a few weeks ago to resist socialized medicine. They came from every single State, including Alaska and Hawaii. And that mobilization of the American people that are determined to defend this country and the values that made this a great Nation is only a smaller part of the energy that’s out there if this President, this majority and this Congress are truly a majority and the Harry Reid majority down the hallway through the center of the Capitol in the United States Senate, if they decide they want to try to overturn comprehensive amnesty to over haul the immigration laws in the United States of America, rather than enforcing them, we’ve seen nothing yet so far this year to what we will see if they try to bring amnesty and force that down the throats of the American people.

The lines have been drawn. The American patriots have stepped up. They understand what’s going on. This is about the rule of law. At the core of the argument on the bill is the rule of law. A Nation cannot be a Nation unless it defends the rule of law. And we have been so proud of the rule of law in America. When I went home over Thanksgiving vacation, I arrived on a Friday morning and I went to Sioux City. One of the things I did that day was to go to a naturalization ceremony at the Federal building in Sioux City. I have spoken to the naturalized groups there a number of times. There were 37 new Americans that took the oath of allegiance to the United States on that day. They were from 11 different countries that I counted, perhaps a couple of more. These are people that today are as much an American citizen as the residents of 1600 Pennsylvania Avenue, or the residents in my house. I welcome the legal immigrants that come into America, that follow the law, that come here, lawfully, to have access to this American dream, because when they do, they will be able to do so for others. The vitality that we have gotten from every donor nation is the cream of the crop off of every donor civilization. It’s one of the things about being an American that’s unique. We’re not just an appendage of Western Europe or the other countries that have contributed people to come to the United States and become Americans. We have a unique vitality, Madam Speaker. It’s rooted in a lot of things. The rule of law is one of the pillars of American exceptionalism. Among them are free enterprise, capitalism and property rights and freedom of speech, religion, assembly and the press and the right to keep and bear arms; and also, the right to be judged by a jury of your peers.

And the rule of law, Madam Speaker. The rule of law says that if you are judged, and I said this to that group of newly naturalized Americans in Sioux City that day, some week and a half or two or three weeks ago, the rule of law in the United States of America, if you’re the richest man in the world, you’ll get the same level of justice that
you get if you’re the poorest man in America. If Bill Gates comes before that court, before the Federal court in Sioux City, Iowa, he’ll be judged on the same standard as the poorest person in that room that day, or the poorest person in the United States. We also saw others on film that were picked up and {

They watched the people that I had arrested. They watched them at the border patrol station in the country. It’s part of that section of 2,000 miles of border from the coast of California all the way to Brownsville. There, as I watched what was happening, we went out and watched as some who were jumped the fence, and they existed. It’s not a good enough fence, but it’s better than no fence. They couldn’t control anything without it. And they monitor the fence. They picked up some illegals that had jumped the fence from Mexico into the United States. We also saw others on film that were picked up and they were brought to the center, the center at the border patrol station in Nogales. Good people work in there that do respect the rule of law.

If you watched the people that I’ve seen arrested because of breaking our immigration law come waltzing into the border patrol station at Nogales, some of them just with a smirk on their face, they turned around and went back to Mexico. The door was open, and it was a good opportunity for them to go back to the border where they go back to Mexico to be caught again, around and around and around an ever-ending circle, and we call that enforcement of immigration law.

But at least, Madam Speaker, we have immigration law. At least it’s against the law to come into the United States and violate the standards that we have; and at least we have penalties that we can impose against the people that do. But we’re here in a Congress that looks like it has the will to start this idea again, this comprehensive amnesty argument again, that if people can get into the United States and they express that they want to stay here, that we should just say, We’ll give you amnesty and we’ll give you a path to citizenship because we don’t have the will to enforce the law.

And this argument, this specious, baseless argument that’s been made by this side of the aisle over and over again, and by some on this side of the aisle too, Madam Speaker, that somehow we’ve allowed illegals to get along without having immigrants, legal and otherwise, and actually they say especially illegal immigrants, to do the work that Americans won’t do. What an offense to the people that are hardworking in America.

Americans are the majority of every single profession out there. And I mean Americans, legal workers in America, are the majority of every single profession out there with the exception of agriculture and farm workers. Everybody else is predominantly Americans. Yet they’ll say there are jobs Americans won’t do. Well, what jobs? Tell me what jobs?

JOHN MCCAIN said, well, Americans won’t pick lettuce and offered $50 an hour. I’d have lost my whole construction crew. They’d have gone down there and picked lettuce for $50 an hour instead of haul dirt for the price we pay them, which isn’t bad, by the way. That argument that there are jobs that Americans won’t do. Well, what jobs? Tell me what jobs?
job that Americans won’t do, let me describe to you the most difficult job there is. The most dangerous, the dirtiest, the most stressful, the riskiest, hottest, dustiest, dirtiest, nastiest job to do is rooting terrorists out of places like Fallujah or Karbala or Ramadi, or Iraq, and the mountains in Afghanistan, for example. That’s the most difficult job there is. It’s the most dangerous. It’s the dirtiest. You don’t get to take a shower every day and sit down and take a coffee break when the bullets are flying and the IEDs are being detonated.

And what do we pay Americans to do that? The lowest ranking marines—a couple of years ago I checked the number—about $8.09 an hour, presuming it is a 40-hour week, and it’s not. Can you look those people in the eye that are defending our safety and our security, Madam Speaker, and say to them, There are jobs Americans won’t do? That marine, that soldier, he’s going to look at you and wonder, why? Is what’s dirtier or more dangerous, what’s nastier than this job that I’m doing for the love of my country? For the love of my country and $8.09 an hour? And we have to take this insult that there’s jobs that Americans don’t do.

Americans do every job. I look at my family. I look at my neighbors. It’s hard to come up with a job that we haven’t done. That includes processing meat. I’ve done a fair amount of it myself. But if I look at the meat processing in my neighborhood, 25 years ago, at about that era of time, if you wanted to get a job in the packing plant around my neighborhood, you had to know somebody to get in. These weren’t union jobs, but you had to know somebody to get a job like that because they paid well. The benefits were competitive with anywhere else. I watched people grow up and maneuver and position themselves to go through school and get out of school so they could line up on the line at the packing plant, just the way a lot of miners got in line to go down and mine some coal or steelworkers lined up at the mill or whether it’s the packing plant or food processing or whatever it might be, and if you look to their right and they see someone whom they suspect is illegal, and may well know that they are, and they look to their left and you suspect that they suspect is illegal, or know that they are, they need to understand that on their right and left likely are jobs that Americans would be doing if those positions weren’t taken by those who broke into this country to over-stay their visas, Madam Speaker.

Here we are with the President of the United States tomorrow having his jobs summit at the White House. And there you will see a collection of Keynesian economists, the kind of brains that brought about all these things that I’ve talked about, from TARP funding to the nationalization of the investment banks and AIG and Fannie Mae and Freddie Mac and General Motors and Chrysler; first $700 billion and an economic stimulus plan; the kind of brains that decided we should tax all the energy consumed in America and tell America that we’re going to create green jobs; the kind of people that can’t draw a distinction between the private sector and the public sector; people that don’t understand that it’s the private sector that produces all of the new wealth that’s necessary—in fact, all of the wealth that’s necessary—this year, next year, the year after that, the year after that, the year after that, the year after that, etc., that it’s the private sector. And that out of that wealth that comes from the private sector is skimmed the funding that goes into the government machinery. It has been so convoluted over the last generation or so that economists can go through a college education and work and get their master’s and really not have much exposure to where the new wealth comes from.

I need to make this point, Madam Speaker, that the American people need to understand there’s a distinction between the private sector—the productive sector of the economy—and the public sector of the economy—the parasitic sector of the economy, the sector of the economy that comes from government that taxes production and punishes production and regulates production until it defeats the very spirit of the entrepreneurs that start the companies that create the jobs.

We tell our constituents from the entrepreneurs, they aren’t just based on some esoteric dream like we seem to be getting out of the White House economists that we will hear about tomorrow. The idea that we have out there, I can’t draw a distinction very much between what is going on between the years of Larry Summers, for example, or someone who may believe that they can always keep pushing the system further ahead. We have heard of those people.

Madam Speaker, my news to the White House is this American economy is not just simply a large magic chain letter that you can stimulate some people to make another investment that you, the government, can get a cash out of the next group of suckers in the chain and they would get theirs out of the next group of suckers. That’s what a chain letter does. That’s what a government-driven economy does. It always has to find another group of suckers to be the ones becoming the ones that are producing some wealth in the private sector.

Now where does wealth come from? It comes from the production of goods and services, first, that are essential to the survival of mankind, to the production of goods and services that improve the productivity of those goods and services that are essential to the survival of mankind.

If it’s the clothing and shelter, the things that we must have if we’re going to live, if you produce those things, you’re at the foundation of the new wealth. If you produce those things that make us more efficient in producing those essentials for life, you’re at the second level of the economy. The third level is the disposable income that comes that’s in excess to the necessities that are required to replace your capital investment and the necessities that are required to continue the production of the necessities of life. And so that’s the disposable income. That’s the income we use to add those things to our quality of life that allow us to go to Disney World, to go on vacation, travel around. Those are the things that we call the things that are really entertaining that we call the services that are essential to the growth of mankind.

So there are the levels of the economy and all new wealth comes from the land or out of Mother Earth. And whether you want to mine some gold or some platinum or whether you want to raise some corn or soybeans or cotton or peanuts, all of these things add to our ability to provide for the survival of mankind and, second, to the efficiency of mankind. And when we do that well enough, we’ve got disposable income and the Federal Government
and other political subventions come in and skim the cream off that production out of the private sector that I’ve just described.

And then you have people like those who have been appointed by the President, the President himself, who sit back, get this thoughtful look on their face, and they think, Let me see, if I could bor-row a few hundred billion dollars from the Chinese and promise to pay interest on that hundred billion dollars, then I could drop this money in and I could do a few hundred billion dollars’ worth of patronage—patronage jobs that will call for more political loyalty and the government jobs that are temporarily created by the taxation and the borrowing that takes place.

Never mind about 4 years from now or 8 years or a decade or two or a generation from now. We’ll just borrow that money now and drop this into the economy and give this big, giant economic injection of that letter a spin. That’s what’s been going on, but it has gone into over-drive in the last year. And while this is going on, we have this immigration policy that’s becoming more and more errant in its philosophy and its results.

I’ve talked about the lack of will to enforce immigration law just by illustrating what we’re doing. We’re doing catch-and-release as opposed to catch-and-release. We’re just returning them to the police department. So catch-return-release is a better way to describe what is going on with immigration law in the United States. We have a Secretary of the Department of Homeland Security that has essentially said, I’m not going to go out and do raids on employers, even if I know there might be thousands there that are working there illegally. She’s essentially said that she just wants to go in and find the employers that are violating immigration law.

Now, I think we should do that; but I think when we encounter people that are in this country illegally, whether they’re working or whether they aren’t, we have an obligation when we encounter people unlawfully present in the United States to take them back and put them where they’re lawfully present. All we’re doing is putting people back into the condition they were in before they broke the law. Deporting someone from Miami and deporting them to the Bahamas, they’re working illegally. We have to have, in a Nation with a government, enforcement take a position that they aren’t, we have an obligation when we encounter people unlawfully present in the United States of America while they’re working or whether they

the number is greater than that. These numbers work like this: there are 287(g) program to be refurbished again to what it was before it was distorted by the Secretary of Homeland Security for the purposes, I believe, of jerking the 287(g) local law enforcement cooperation—and of understanding rug out from underneath Sheriff Joe Arpaio down in Maricopa County. It was one of the strong motivations that took place.

We have a Nation with a rule of law, we have got to have co-operation at all levels of government with all laws. We cannot have local law enforcement take a position that they don’t have the authority to enforce immigration law. Of course they do. The Attorney General should know that. There’s an Attorney General’s opinion that supports it; a previous Attorney General actually under Ashcroft. There are several Federal court cases that support the authority and the jurisdiction of local law enforcement to enforce Federal immigration law.

And I could drop those all into the RECORD here tonight, Madam Speaker. They are a matter of fact here in America, no matter how they have tried to disguise the open borders people don’t want to enforce immigration law. They want to see a greater number of people come into the United States, and they want to empower themselves politically with the masses of those that are here illegally.

But they’re running up against a little problem, Madam Speaker. This problem is the growing problem of unemployment in America: the pressure on our economy—the pressure on our employment in America: the pressure on our economy will push more and more of those that are here illegally into the open borders and they will have greater numbers of people come into the United States, and they want to empower themselves politically with the masses of those that are here illegally.

Now, if you look at these numbers, these numbers work like this: there are approximately, according to the Pew Hispanic Center, 8 million illegals working in the United States. I think the number is greater than that. These numbers can be verified, I believe, by solid analysis. It’s not under that unless the suppression of the economy has originally had part of the new jobs lost at that rate, those jobs gone, disappeared. But at the same rate, 900,000 jobs taken up by legal immigrants, not to count the illegal immigrants that we have, and we had a net annual loss of jobs about 1.1 million, 380,000 net loss of jobs as a result of the 900,000 green cards. We have 8 million—perhaps as low as 7—but 8 million illegal workers in America. You add that to the number of people you have a pressure on this economy that is just an awesome thing to think that we have a President of the United States that declared that his stimulus plan was going to go to, Madam Speaker, he said—and I’m almost embarrassed to repeat this—save or create 3.5 million jobs by September of 2010. I believe that’s the date that he gave in that. Save or create 3.5 million jobs by September, 2010, if we just put another $787 billion into the economy, which was the hope that happens to be approved and authorized in one fashion or another. However it was used is another story.
districts that don’t exist. Just for the State of Iowa, on this Web site, recovery.gov/transparency, for the jobs that were created in western Iowa, alleged to have been created. These are the district numbers. Seventh, Eighth, 16th, 17th, 19th, 24th, and 31st Iowa Congressional Districts, jobs created at the cost of $862,498, and that leaves off the double-aught district of the State of Iowa. That’s zero-zero. That’s double goose egg. That’s nonexistent, if you could put nonexistent there without a decimal point and carry it out to infinity. There they spent $114,000 to create five nonexistent jobs.

This is what’s going on with these Keynesian economics on steroids while they’re poppin up immigration, while we have Americans that need jobs, want jobs, line up for jobs. While this is going on, we have this kind of fuzzy math accounting and a complete mis-understanding of how wealth comes from, a complete misunderstanding of the foundation of our economy. And I know John Maynard Keynes had some ideas, and I know he has got followers, and I know FDR was one of them. But Keynes was the man who said in the 1930s, I can solve all of your unemployment in America. Just take me to an abandoned coal mine, and I will go out and drill a bunch of holes out there, and I will bury American cash in the bottom of the coal mine that was filled with garbage. That was Keynes’ idea, and I know he was sounding facetious, but, giving a little bit for his sense of humor and for his sense of accuracy, because we have spent a lot of money in this country, dug holes and filled them back up figuratively without putting the money in it, just put money in the hole.

Do Americans want jobs? Absolutely they do, Madam Speaker. And here’s what’s going on—today. Day labor gatherings right alongside groups of illegals who have, some of them, decided to stay in this country because of the lack of opportunity here. The unemployment rate is 10.2 percent. Seven to eight million working illegals, as I said. That’s about 15.7 million unemployed, and Madam Speaker. If you add to that 70 percent of the illegals workers in America who are unemployed and, by definition, are looking for a job, there is another 5.5 million or more who have exhausted their unemployment benefits who don’t quite fit the definition that are looking for a job. There are more than 20 million Americans that want a job today. The American workforce, of 154.4 million of our total workforce, there are over 70 million Americans of working age who are not working. Over 70 million. We could tap into a workforce of more than 70 million people of working age that are just simply not working because the wages don’t pay enough, the benefits are... Maybe they’re independently wealthy. Maybe they’re in between jobs, but they’re all hirable if you make a good enough offer.

These are Americans that will work. There are 70 million non-working Americans of working age, 7 million to 8 million working illegals, and they tell us that they are jobs Americans won’t do, and we won’t possibly run our economy unless we have these millions of illegals and workers that are here, but they don’t want to give them amnesty and legalize them. All we have to do, Madam Speaker, is hire 1 out of 10 of the Americans who are of working age and not in the workforce, put them into those jobs, and we could easily replace—by hiring 10 percent of the non-working Americans of working age, we could replace every illegal in America, according to these numbers, that are produced by the Pew foundation. If it’s double that, I don’t know. I’ll take 20 percent, 2 out of 10 of Americans. We’re looking at more than 20 million Americans that are looking for work. I think this is an easy solution for us. And by the way, we are wiping out 900,000 jobs a year because of legal immigration, green cards that we’re granting at the rate of 75,000 per month. That number I believe is 780,000 so far this year.

Before the recession began, the Federal Government issued 830,000 green cards in the previous year. Last year, during the first year of the recession, the government granted 675,000 new green cards and we’re at the point to go to 900,000 or more this year.’’ There were 900,000 jobs granted to people who were—at the time the card was advanced—not Americans, while Americans are lined up 20 million deep. We’re tripping out almost 1 million jobs a year because of the legal immigration, and we know that there are 7 million to 8 million or more jobs that are taken by illegals, and we know that if we enforce the law—if we enforce a law for every illegal that’s removed from a job, it cannot grant a job slot for an American to step into.

Madam Speaker, any sane nation would go after this enforcement. They would adjust their immigration policy to reduce the legal immigration because of the recession we’re in. Here is what’s going on in this chart, Madam Speaker. The workforce enforcement free-fall—what we’ve seen happen is, the unemployment has gone up 58 percent overall. At the same time that happened, here is the enforcement that has gone down. Department of Homeland Security administrative arrests are down 68 percent; criminal arrests are down 60 percent; criminal indictments are down 58 percent, almost reflecting the same; criminal convictions are down 63 percent. This whole level is down roughly 60 percent or a little bit more in the enforcement of our immigration laws, while unemployment is up almost the same thing, almost 60 percent.

What nation that needs a sound economic policy would go down this path of reducing its enforcement of immigration law while it watched unemployment go up to 10.2 percent and rising to 15.7 million by definition unemployed, more than 20 million altogether, and still we grant green cards at the rate of 900,000 a year. And every one of them supplants—if they go to work, they supplant a job an American that’s doing otherwise—work. They work, they supplant a job an American that’s doing otherwise. I will tell the Speaker, I will tell the Chair, I will tell the White House, I will tell the Congress, I will tell the President, I will tell the Nation, I will tell the world, I will tell the world, I will tell the world, I will tell the world, I will tell the world. I will tell the world that if you or I or anyone else in this room were in the White House, we would go after this enforcement.

I’m for a tighter labor supply, Madam Speaker, I’m for the kind of labor supply that will allow that person who grew up in this country or comes legally to this country to go to work and earn a living and be able to claim a salary and benefits package that they can live on, that they can
raise a family on. And yes, today it takes two workers in a family to make this happen. Mom and dad to raise the kids, working together and making ends meet as best they can.

But that’s not really possible today for so many American families. Their dreams have been taken away by illegal immigration. And somewhere, somewhere in America thousands of times over, over Thanksgiving and coming up for Christmas, there will be a brother, a sister, or a grandfather, or a brother and a sister, siblings sitting around the table, and they’ll say grace and ask the blessings on their turkey, and they’ll start to talk as they eat, and somebody will be unemployed. And their brother or sister will have a job, and they’ll understand that there are people who are in the United States illegally that are filling those slots that they could have, and this discussion, which becomes a nationwide discussion, the rejection of amnesty starts to swell.

As the subject is brought forward here before this Congress—if it is—you will see the American people rise up, and their rejection of amnesty that we saw in 2006 and ’07 will be child’s play compared to the anger of the American people who see themselves employed, 20 million or more, watching them being replaced by legal immigrants at the rate of almost 1 million a year and watching 8 million, or maybe twice as many, illegals working in America, taking jobs that Americans will do.

In fact, taking jobs, according to the USA Today article that I referenced, that Americans are standing in line to do right next to people—that if I needed to come and hand out the work permits, they would be compelled to deport many of these workers. This Nation does not have a logical and coherent enforcement of immigration law.

One of the things we need to do for a tool, the Speaker to pass my New IDEA Act. The acronym is this: The New Illegal Deduction Elimination Act. It brings the IRS into this so that the IRS—it clarifies to the IRS that wages and benefits are not deductible for income tax purposes. It allows the IRS to do the audit and deny the business expense of wages and benefits paid to illegals, which takes—the interest and the penalty and the tax liability that accrues from that decision at a 54 percent rate, will take your $10 an hour illegal up to $16 an hour.

Employers will understand that they would rather go with the legal worker at $13 or $14 an hour than the illegal that could cost them $16 an hour, and we have the IRS into this. They love enforcing their work, I know that. So we bring the IRS into the mix, and they would be required under the New IDEA Act to cooperate with the Social Security Administration and the Department of Homeland Security. We can shut down this jobs magnet. We can control this border. We can reestablish the rule of law in America. We can reinvigorate this economy, and we can produce a tight enough labor supply that the wages and benefits paid to our workers, whatever their education level is—if they’re willing to work, they need to be able to sustain themselves in this society.

We’re moving away from it today. We can move this back. We can refurbish the middle class in America. That’s one of our charges during this time. It’s one of our opportunities during this time, Madam Speaker. And I urge that you and everyone in this Congress bring special attention to the preservation of the rule of law which is more important than our economy is today in this country.

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SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. MCGOVERN) to revise and extend their remarks and include extraneous material:)

Ms. LEE of California, for 5 minutes, today.

Mr. MCGOVERN, for 5 minutes, today.

Ms. WOOLSEY, for 5 minutes, today.

Ms. ROS-LEHTINEN, for 5 minutes, today.

Mr. DOGGETT, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Mr. GRAYSON, for 5 minutes, today.

Mr. KING, for 5 minutes, today.

Mr. JONES, for 5 minutes, December 8 and 9.

Ms. ROBERTS, for 5 minutes, today December 3 and 4.

Ms. CORBETT, for 5 minutes, today December 3 and 4.

Mr. FLEMMING, for 5 minutes, today December 3 and 4.

Ms. FOXX, for 5 minutes, today.

SENATE ENROLLED BILL SIGNED

The Speaker announced her signature to enrolled bills of the Senate of the following titles:
S. 1599. An act to amend title 36, United States Code, to include in the Federal charter of the Reserve Officers Association leadership positions newly added in its constitution and bylaws.
S. 1600. An act to permit each current member of the Board of Directors of the Office of Compliance to serve for 3 terms.

ADJOURNMENT

Mr. KING, Madam Speaker, I move that the House do now adjourn.
for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. BUCK (for himself, Mr. AXIN, Mr. CARMAHAN, Mr. GRAVES, Mr. HILLS, Mr. SULLIVAN, Mr. ISRAEL, Mr. WILSON of South Carolina, and Mr. CARTER).

H.R. 4177. A bill to provide emergency disaster assistance to certain agricultural producers that suffered losses during 2009, to provide emergency disaster assistance to certain livestock producers that suffered losses during 2008 or 2009, and for other purposes; to the Committee on Agriculture, and in addition to the Committee on Appropriations, for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. CLEAVER (for himself, Mr. FRANK of Massachusetts, Mr. MOORE of Kansas, Mr. PAUL, Mr. WATT, Mr. MARCHANT, Mr. TUTTLE, Mrs. CASTRO, and Mr. BACHUS).

H.R. 4178. A bill to amend the Federal Deposit Insurance Act to provide for deposit restricted qualified tuition programs, and for other purposes; to the Committee on Financial Services.

By Mr. CONVERS (for himself, Mr. JOHNSON of Georgia, Ms. LEH of California, and Mr. MASSA).

H.R. 4179. A bill to amend the Internal Revenue Code of 1986 to keep Americans working by creating a public work-sharing tax credit that stimulates demand in the private sector labor market and provides employers with an alternative to layoffs; to the Committee on Ways and Means.

By Mr. HASTINGS of Florida (for himself, Mr. MORAN of Virginia, Mrs. CAPPS, Ms. BERKLEY, Ms. NORTON, Mr. STARK, Ms. WATSON, Ms. EDWARDS of Maryland, Mr. GRIJALVA, Mr. GRAYSON, Ms. CHU, Mr. MEERS of New York, Mr. CUMMINS, Mr. HALL of New York, Mr. ACKERMAN, Mr. SPEIER, Ms. LORETTA SANCHEZ of California, Mr. ELLISON, Mr. DINGELL, Mr. BLUMENTHAL of Connecticut, Mr. WOOLSEY, Ms. KILHORN of Michigan, Ms. CLARKE, Ms. PINGER of Maine, Ms. HIRONO, Mr. FILNER, Mr. ABERCROMBIE, and Mr. WATT).

H.R. 4180. A bill to amend title 10, United States Code, to include the disclosure of sexual orientation by a member of the Armed Forces to a Member of Congress as a lawful and protected communication and to prohibit retaliatory personnel actions against members of the Armed Forces who make such disclosures; to the Committee on Armed Services.

By Mr. BRUCE.

H.R. 4181. A bill to provide grants to States to improve high schools and raise graduation rates while ensuring rigorous standards, to develop and implement effective school models for struggling students and dropouts, and to improve State policies to raise graduation rates, and for other purposes; to the Committee on Education and Labor.

By Mrs. LOWEY.

H.R. 4182. A bill to amend the Homeland Security Act of 2002 to limit the number of Urban Area Security Initiative grants awarded and to clarify the risk assessment formula to be used when making such grants, and for other purposes; to the Committee on Homeland Security.

By Mr. MCDERMOTT (for himself, Mr. WOOD, Mr. CONEY, Mr. SIREN, Mr. ACKERMAN, Ms. SCHAKOWSKY, Ms. HIRONO, Mr. LEWIS of Georgia, Mr. CAPUANO, Ms. DELAUNAY, Mr. MICHAUD, Ms. WOOLSEY, Ms. GRIJALVA, Mr. KILDEER, Mr. LEVIN, Mr. CARDOZA, Ms. BERKLEY, Mr. ELLISON, Mr. DÉFAZIO, Ms. PINGREE of Maine, Mr. LANGEVIN, and Ms. McCOLLUM).

H.R. 4183. A bill to amend the Assistance to Unemployed Workers and Struggling Families Act to eliminate the $100 million appropriated in the fiscal year 2010 to issue and provide grants, and to clarify the risk assessment formula to be used when making such grants, and for other purposes; to the Committee on Ways and Means.

By Mr. POMEROY.

H.R. 4184. A bill to amend the Internal Revenue Code of 1986 to make permanent the qualified deduction; to the Committee on Ways and Means.

By Mr. POMEROY.

H.R. 4185. A bill to amend the Social Security Act and the Internal Revenue Code of 1986 to exempt certain employment as a Federal employee and certain employment benefits, and for other purposes; to the Committee on Ways and Means.

By Mr. POMEROY.

H.R. 4186. A bill to amend the Internal Revenue Code of 1986 to extend for 2 years the treatment of certain farming business machinery and equipment as 5-year property for purposes of depreciation; to the Committee on Ways and Means.

By Mr. MCCABE (for himself, Mr. HERGER, Ms. HERSEY SANDLIN, and Mr. BRALLY of Iowa).

H.R. 4187. A bill to amend the Social Security Act and the Internal Revenue Code of 1986 to exempt certain employment as a Federal employee and certain employment benefits, and for other purposes; to the Committee on Ways and Means.

By Mr. POMEROY.

H.R. 4188. A bill to provide for the operation, management, and administration of the Airport Improvement Program for fiscal year 2010; to the Committee on Transportation and Infrastructure.

By Mr. SESTAK (for himself, Mr. FALLON, and Mr. GRIJALVA).

H.R. 4189. A bill to amend the Water Resources Development Act of 1996 to make modifications to the Chesapeake Bay environmental restoration and protection program; to the Committee on Transportation and Infrastructure.

By Mr. SESTAK (for himself, Mr. FALLON, and Mr. GRIJALVA).

H.R. 4190. A bill to authorize appropriations for brownfields site assessment and cleanup, and for other purposes; to the Committee on Energy and Commerce, and in addition to the Committee on Transportation and Infrastructure, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. MATHESON (for himself, Mr. ALIOTO, Mr. ABERCROMBIE, Mr. BACA, Mr. BAIRD, Mr. BARROW, Ms. BENJAMIN, Mr. BISHOP of Utah, Mr. BOREN, Mr. BOSWELL, Mr. BOUCHER, Mr. BOYD, Mr. BRADZELL, Mr. CHILDERS, Mr. CONAWAY, Mr. COOPER, Mr. COSTA, Mr. CUELLAR, Mr. DAVIS of Tennessee, Mr. DAVIS of Alabama, Mr. DINGELL, Mr. DONNELLY of Indiana, Mr. DOYLE, Mr. ELLSWORTH, Mr. ETHERIDGE, Mr. GONZALEZ, Mr. GORDON of Pennsylvania, Mr. HUFF, Mr. DISCH, Mr. HERSHETH SANDLIN, Mr. BILL, Mr. HODES, Mr. HOLDEN, Ms. INLIE, Mr. ISRAEL, Mr. KIND, Mr. KRATOVIL, Mr. LARAUR of Connecticut, Mr. MELANCON, Mr. MCNICHOL, Mr. MITCHELL, Mr. MOORE of Kansas, Mr. NATICK, Mr. MURPHY of Pennsylvania, Mr. MURPHY of New York, Mr. NYS, Mr. RAY, Mr. SALAZAR, Mr. SCHIFF, Mr. SCOTT of Georgia, Mr. SHULER, Mr. SMITH of Washington, Mr. SPARKS, Mr. TANNER, and Mr. UPTON): H.R. Res. 942. A resolution commending the Real Salt Lake soccer club for winning the 2009 Major League Soccer Cup; to the Committee on Oversight and Government Reform.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 43: Mr. TIM MURPHY of Pennsylvania, Mr. THORNBERRY, Mr. REHBERG, and Mr. ACKERMAN.

H.R. 223: Ms. CHU.

H.R. 233: Mr. BEAN.

H.R. 305: Mr. POLIS of Colorado.

H.R. 432: Mr. COSTA.

H.R. 470: Mr. SOUDER.

H.R. 482: Mr. HINCHEN.

H.R. 537: Mr. GRIIDL.

H.R. 571: Ms. WOOLSEY.

H.R. 606: Mr. WATSON.

H.R. 646: Mr. JOHNSON of Georgia.

H.R. 690: Mr. ADLER of New Jersey.

H.R. 699: Mr. MORA of Virginia.

H.R. 725: Mr. BACA.

H.R. 734: Mr. RICHARDSON.

H.R. 739: Ms. SLAUGHTER.

H.R. 768: Mr. LULIAN.

H.R. 847: Mr. MARKEY of Massachusetts.

H.R. 916: Ms. BALDWIN and Mrs. CAPPS.

H.R. 930: Mr. MORAN of Virginia.

H.R. 960: Mr. PERLISIUS and Mr. CONNOLLY of Virginia.

H.R. 1045: Mr. PERLISIUS and Mr. CONNOLLY of Virginia.

H.R. 1204: Mr. SPRATT.

H.R. 1215: Ms. WATSON.

H.R. 1230: Mr. CLAEVER.

H.R. 1236: Ms. SLAUGHTER.

H.R. 1318: Mr. MCMANUS.

H.R. 1362: Mr. FRANK of Massachusetts.

H.R. 1463: Mr. PERRIELLO and Mr. PITTS.

H.R. 1585: Mr. MORAN of Virginia and Ms. PUGH.

H.R. 1623: Mr. MCCOTTER and Mr. MARCHANT.

H.R. 1628: Mr. BILBAY.

H.R. 1792: Mr. TERRY.

H.R. 1869: Ms. BERRIED, Mr. WALTZ, Ms. TSONGAS, Ms. GIFFORDS, and Mr. LEWIS of Georgia.

H.R. 1880: Mr. CUMNAH.

H.R. 1974: Mr. SCOTT of Virginia and Mr. WOLF.

H.R. 2006: Mr. Bishop of Georgia, Mr. DEFAZIO, and Ms. EDIE BERNICE JOHNSON of Texas.

H.R. 2068: Mr. WOLF.

H.R. 2074: Mr. NADLER of New York, Mr. JOHNSON of Georgia, Mr. HONDA, Mr. SHIRES, Mr. SCHIFF, Ms. MCCOLLUM, Mr. TONKO, Mr. BRALLY of Iowa, Mr. GRIJALVA, Mr. MASSA, Mr. DAVIS of Illinois, Ms. CORRINE BROWN of Florida, Mr. DUNHAM of Maine, and Mr. PASTOR of Arizona.

H.R. 2105: Ms. SLAUGHTER.

H.R. 2115: Mr. LOESEK.

H.R. 4121: Mr. SOUTHWORTH.
The Senate met at 9:30 a.m. and was called to order by the Honorable Tom Udall, a Senator from the State of New Mexico.

**PRAYER**
The Chaplain, Dr. Barry C. Black, offered the following prayer:

> Let us pray.

Eternal God, thank You for the gift of this day. Help us to use it for Your glory. Guide our lawmakers to labor with diligence for the good of our Nation. Deliver them from bitterness, frustration, and futility as they lift their eyes to You, their ever-present help for life’s difficulties. Lord, save them from the futile repetition of old errors and the restoration of old evils. May they live such exemplary lives that people who see their good works will glorify You. Use the Members of this body to increase opportunities for more abundant life to people everywhere. Help our lawmakers to be aware of Your nearness and to recognize Your voice as You lead them to Your desired destination. We pray in Your sacred Name. Amen.

**PLEDGE OF ALLEGIANCE**
The Honorable Tom Udall led the Pledge of Allegiance, as follows:

> I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

**APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE**
The Presiding Officer. The clerk will please read a communication to the Senate from the President pro tempore (Mr. Byrd).

The assistant legislative clerk read the following letter:


To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable Tom Udall, a Senator from the State of New Mexico, to perform the duties of the Chair.

> ROBERT C. BYRD, President pro tempore.

Mr. UDALL thereupon assumed the chair as Acting President pro tempore.

**RECOGNITION OF THE MAJORITY LEADER**
The Acting President pro tempore. The majority leader is recognized.

**SCHEDULE**
Mr. REID. Mr. President, following leader remarks, the Senate will resume consideration of the health care reform legislation. It will be for debate only until 11:30 a.m., with alternating blocks of time. The first 30 minutes will be under the control of the Republicans; the majority will control the next 30 minutes.

The Senate will recess from 11:30 a.m. until 12:30 p.m. today. Following the recess, the Senate will resume consideration of the health care legislation. I am hopeful we can have some votes on health care legislation. It will be for debate only until 11:30 a.m., with alternating blocks of time. The first 30 minutes will be under the control of the Republicans; the majority will control the next 30 minutes.

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**HEALTH CARE REFORM**
Mr. REID. Mr. President, this historic health care reform bill before us is strong, and it is a strong head start in the right direction toward urgently needed change. But similar to nearly every bill to come before the Senate, it stands to benefit from the constructive input of all Senators. This good bill will be even better when this body debates it, refines it, and improves it.

I am pleased we have begun the amendment process. I hope we will soon be able to begin voting on those amendments—the ones drafted and sponsored by both Republicans and Democrats. But as we delve into the details and give the individual parts of this bill the considerable thought and attention they deserve, let’s not forget the big picture.

As we begin the third day of debate on this bill, let’s remember what it does: First, we are making it more affordable for every American to live a healthy life. Second, we are doing it in a way that is fiscally responsible and in a way that will help our economy recover.

This bill does not add a dime to the deficit—quite the opposite. In fact, we will cut it by $130 billion in the first 10 years and as much as $4 trillion in the next 10 years. We do this by keeping costs down. This critical piece of legislation will cost less than $85 billion a year over the next decade—well under President Obama’s goal. It will make sure every American can afford quality health care. We will make sure that more than 30 million Americans who don’t have health care today will soon have it. It will not only protect Medicare, but it will make it stronger. In short, this legislation saves lives, saves money, and saves Medicare.

The Congressional Budget Office and respected economists outside Washington have studied it, and they agree. The bill will do what we set out to do at the beginning of this Congress: It will lower costs and increase value so all Americans can afford quality health care, not just a few.

The experts have crunched the numbers, and they have come back with positive reviews. It will help parents afford to take care of their children and help bosses provide coverage for their workers. It creates more choices and more competition in the health care market. It will protect everyone against insurance company abuses, and for all the changes, in areas where our health care system does work, it keeps it the way it is.

I am very happy with the way Democratic Senators have stood for these
principles and those who have defended them against hollow attacks from the other side. One after another, Republicans have come to the floor with disingenuous claims.

For example, they have talked about health care premiums, overlooking the fact that those costs will go down for the vast majority of Americans—in fact, 93 percent. They have talked about the deficit, ignoring the fact that health care reform will do more to lower the deficit than any other measure in years—remember, over 20 years, almost $4 trillion. They have tried to scare seniors, saying you are going to die soon, as an example, closing their eyes to the fact that we strengthen Medicare and cut waste, fraud, and abuse from the program. They have tried to scare women, closing their ears to the fact that we will make it easier than ever for women to get the preventive screenings they need, and that is a gross understatement. They claim to speak for the American people but neglect to mention that, for the last year, a majority of the American people have consistently said it is more important than ever to nurse our health care system back to health.

What is the most consistent Republican attack on this bill? They carefully select the number of pages in this legislation but completely discount the number of people it helps. Can anyone think of a more superficial way to measure the worth of a bill than how many pages it is printed on? As far as I can tell, the only threat that poses is more paper cuts, perhaps.

Those who want to keep the broken system the way it is throw everything they can at the wall, but nothing has stuck. Incredibly, my distinguished counterpart, the Republican leader, last week, called the health care crisis manufactured, in spite of the fact that 750,000 people filed for bankruptcy last year—70 percent of them because of health care costs. In one sense, my colleague’s Republican counterpart is right—it was manufactured. This health care crisis has been manufactured by the greedy insurance companies that raise families’ rates on a whim and deny health care to the sick.

Remember, the health care industry is exempt from the antitrust laws. They can conspire to fix prices with no civil or criminal penalties. No other business is like that, except baseball. This was manufactured by major players who enabled them, who empowered them, and who sat idly by while the problem grew worse and worse, until it finally collapsed into a crisis.

My Republican friends have been so busy coming up with distortions that they have forgotten to come up with solutions. They seem more concerned with scaring the American people than helping them. This barrage of baseless accusations underscores how desperate some are to distract the American people from the real debate and from the fact they have no vision for fixing our health care system, which is broken.

Yes, correcting the record has taken a long time. That is OK. We will continue to do so as long as necessary. Democrats are more than willing to defend this good bill. After all, it is not hard to do. As Mark Twain, a great Nevadan, said: “If you tell the truth, you don’t have to remember anything.”

I wish to note that I especially appreciate the assistant leader, my friend of decades, Senator DURBIN, for his brilliant statements on the floor during the last several weeks on this health care issue. I wish to admire his spunk, his intelligence, and his ability to deliver a message.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of H.R. 3590, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time home buyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid amendment No. 2786, in the nature of a substitute.

Mikulecky amendment No. 2791 (to amendment No. 2786), to clarify provisions relating to first-dollar coverage for preventive services for women.

McCain motion to commit the bill to the Committee on Finance, with instructions.

The ACTING PRESIDENT pro tempore. Under the previous order, the action of the Senate until 11:30 will be to consider the bill, with alternating blocks of time, with Republicans controlling the first 30 minutes and the majority controlling the second 30 minutes.

The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. KYL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. KYL. Mr. President, to continue our debate on the McCain amendment to ensure Medicare benefits for our seniors are not cut, as would happen under this legislation, I wanted to talk a little bit about the commitments we have made to our seniors and what exactly would happen under the legislation that is before us.

As we all know, seniors have paid into the Medicare Program, and that is

with the expectation that they will get the benefits that have been promised to them. The question is, Why would we, at this point, reduce the benefits that have been promised to them, especially if the purpose is not to enhance the financial viability of Medicare, which everyone knows is going broke but, rather, to use that money to establish a new entitlement program?

Let me break down the list of cuts seniors would face under this legislation. For example, a $5 billion would be cut from hospitals that treat seniors. $120 billion from the Medicare Advantage plan. By the way, that Medicare Advantage plan serves almost 40 percent of the Arizona seniors on Medicare. It cuts $14.6 billion from nursing homes, $42.1 billion from home health care, and $7.7 billion from hospice care. These are deep cuts, and you cannot avoid jeopardizing the health care seniors now have under Medicare by making these deep cuts. That is why the Chief Actuary at the Centers for Medicare and Medicaid Services—we use the initials CMS—believes these cuts would cause some providers to end their participation in Medicare, which, of course, would further threaten seniors’ access to care. There would not be as many providers to whom they could go for their services.

Our friends on the other side of the aisle say part of this is an intention to eliminate waste, fraud, and abuse. Of course, we have known for many years that there is waste, fraud, and abuse in Medicare, but actually doing something about the problem and recognizing it are two different things. If it were easy to wire hundreds of billions of dollars of savings from Medicare by just pointing to waste, fraud, and abuse, we would have done it a long time ago. Certainly the President would, during his first year in office, want to do that, given the fact we are leaving a lot on the table. He is trying to find sources of revenue for the various spending programs he has proposed. If it were that easy to do, it would have been done before now.

Moreover, Medicare faces a $38 trillion, 75-year unfunded liability. That is almost incomprehensible. Most of us believe that whatever savings we could achieve in Medicare, to the extent you could eliminate waste, fraud, and abuse, for example, you should do that to help make Medicare more sustainable, which is how I would happen under the legislation that is before us.

As we all know, seniors have paid into the Medicare Program, and that is

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of benefits such as dental, vision, hearing, physical fitness programs, and other things, as I said, that they could not get otherwise. One in four of the beneficiaries in Arizona, as I said, signs up for this program—more than $29,000 seniors. They like the low deductibles and copayments in Medicare Advantage.

But the Congressional Budget Office has bad news for the seniors who like this program and who like the extra benefits they have under Medicare Advantage because, as the Congressional Budget Office notes, it would cut benefits on average by 64 percent over the next 10 years, from an actuarial value of $135 to $49 a month. Think about that. The actuarial value of the benefits the average Medicare Advantage participant has is worth $135 a month today. It would be cut in this bill to $49 a month. That is a 64-percent cut, according to the Congressional Budget Office. When we say we are not cutting benefits senior currently receive, that is not true. The legislation would do that.

I have been sharing letters from constituents who have expressed concerns to me. Let me share three more letters today.

One recently arrived from Joseph and Mary-Lou Dopak of Sun City West, in Arizona, of course. They wrote as follows:

“The plan to reduce our coverage and take $20 billion from Medicare Advantage is a slap in the face to all seniors. The Medicare Advantage plan works because Medicare funds are given to a private insurance company to administer the plan. We do not want our Medicare Advantage plan robbed to fund a government-operated comprehensive health insurance plan. Common sense tells us that will not work.

The President should be fixing what ails the current health care system, instead of putting his own agenda into a government-operated health care plan.

For our President to pick on Medicare Advantage is totally unfair to those of us upon whose shoulders this country has been built.

A constituent from Tucson, AZ, wrote a rather short and direct letter, and so it is easy to quote here.

I am a senior citizen age 83. If I lose my Medicare Advantage coverage, I’ll also lose my primary care physician of 14 years because he does not accept Medicare Direct. Senator Kyl, do not let them take away my Medicare Advantage.

I get these letters every day. I have not yet had a constituent come up to me and say: Please, would you take away the Medicare Advantage Program, it is not right. Everybody has said, of course: Please preserve this important program.

Finally, a constituent from Phoenix, AZ, who suffers from multiple sclerosis, describes what it means to her.

I am a 57-year-old woman with multiple sclerosis, currently on Social Security Disability, I receive $14,000 a year and have been on the Secure Horizons Medicare Advantage plan for a long time now.

I realize it is hard for Congress to understand why we need to keep our Medicare Advantage plans in order to have [quality] health care at a price we can afford.

We need you to help protect Medicare Advantage plans for the seniors in your State. We are the ones you need to fight for and we should not have to choose between going to the doctor and getting our medications and having food on the table and a place to live. Please do your part to protect our Medicare Advantage plans and keep prices within our reach.

As I said, these are the kinds of letters we get all the time. It is hard for these folks to understand, first of all, why, having paid into the plan and having taken advantage of what is a unique program in Medicare, that would be taken away from them. I think it is even harder for them to fathom that the reason it is being done is to pay for a new program rather than to keep Medicare itself solvent.

I tell folks like this that I will continue to fight for her and I will continue to try to protect this program because we believe it is essential. It is why I support the McCain amendment to commit the bill back to committee. It one thing. We are not talking about a further delay here.

But it addresses both of the key issues of cuts and savings. If the McCain amendment passes, it would send the bill back to the Finance Committee to look at the Medicare cuts from the bill. That is all it does. But, second, those savings would be applied to Medicare rather than to fund a new government program. Those savings could therefore address the $135 billion that has been identified by everyone. It can be used to strengthen the Medicare trust fund rather than to fund a new health care entitlement program.

We believe the first thing we should do to see whether we can actually fix this bill—I have been quoted as saying that I don’t think we can fix this bill. By that, I mean, with all due respect to my colleagues on the other side of the aisle, I don’t think they want to make the changes that are necessary for the American people to begin to support this kind of legislation. Seniors are overwhelmingly opposed to the Medicare cuts. That is a fact. If my colleagues on the other side of the aisle are not willing to support the McCain amendment or something like it, I don’t know how we could then say we can fix this bill. So I hope my colleagues will use this process we have to actually make amendments to the bill and not simply have a political discussion.

Republicans have pointed out that there are better ways to reform the health care problems we have today than to do it on the backs of seniors. We put forth a bounty of ideas. Let me just record one.

We think we could start and we could save a great deal of money by medical malpractice reform. That would bring down costs. We could allow Americans to buy lower cost insurance policies across state lines. That alone would unleash a wave of competition for patients’ business. We could allow small businesses to band together to get the same purchasing power big businesses have. These ideas have essentially been ignored by the majority. Instead, we have this big government takeover of health care at a huge cost and significant reduction in quality and benefits to the American people. We don’t think that is the way.

Certainly, on behalf of my senior citizen constituents and others who are on Medicare Programs, I am going to continue to fight for them, as my colleague John McCain is, and therefore urge my colleagues to support his amendment to eliminate the Medicare cuts under this bill.

The ACTING PRESIDENT pro tempore. The Senator from Kansas is recognized.

Mr. BROWNBACK. Mr. President, I rise to speak in favor of the McCain motion, and I do it from the perspective of a representative of the State of Kansas.

We have a number of senior citizens and hospitals that are Medicare-dependent. We have a number of providers for whom a majority of their practice is Medicare reimbursement. They are scared to death of these cuts, and the cuts are well documented. They are—$500 billion for the 43 million senior citizens on a program that is already projected to go insolvent by 2017, specific cuts of $135 billion from hospitals, $120 billion from 11 million seniors in Medicare Advantage, and $15 billion from nursing homes, nearly $40 billion from home health agencies, and then—a cruel gesture, it seems to me—nearly $8 billion from hospice, where people are getting their final care for cancer and diseases that are killing them—$8 billion cut from hospice.

What that does in a State such as mine and in many rural hospitals, it cuts the legs out from under them. They are not going to have the money they need to operate. They are going to do everything they can to continue to operate—and they will, probably. What they will try to do is tax their local citizenry, raise property taxes, in all probability, to make up for the Medicare cuts because they are going to have a hospital there and they are going to do everything they can to keep a hospital there.

But what a terrible gesture on our part here, to take money that has been going into Medicare—and then steal it for a new program that is not going to get everybody covered on top of that and from a program that is already set to go insolvent by 2017. It is like writing a big fat check on an overdrawn bank account to start something new, to buy a new motorcycle. That doesn’t make sense to people. Then it seems cruel and unusual to the senior citizens that you are taking $500 billion and really gutting a lot of their care programs on a program that doesn’t work.

I met earlier, within the last several days, with the Kansas Association of
Anesthesiologists. They are looking at these things and saying: This is really going to hurt us and our ability to provide services and care. I talked with other individuals who look at this, and they say: Wait a minute, you are going to change everything to try to get a few more covered and yet you are going to gut a Medicare program that is not paying the bills now, that a number of private insurance plans are helping to subsidize Medicare and Medicaid, and you are going to cut the reimbursement rates that are not making things work yet? It makes no sense to individuals that this would take place.

I get called by a number of individuals across the State of Kansas saying they are very scared of this bill and what it is going to do to their health care. I do telephone townhall meetings, as a number of individuals across this body do, and the individuals there whom you get on a random phone calling basis are scared and mad about this bill and what it does to their health care. I get it from individuals. I get it from mail.

I was in a meeting in Kansas the week of Thanksgiving, and I polled the audience—it was an audience that was mostly over the age of 65—how many were in favor of the overall bill? There were about 200-some people there, and 10 were in favor. How many opposed? Everybody else, with a few saying they don’t have an opinion. But it was 90 percent opposed to this bill, and it is because they look at it and they see what it is going to do to them, and they don’t see it providing the care that is being promised—and adding, on top of that, to the deficit.

One of two things is going to happen on these Medicare cuts, because we have seen, in the past, efforts to control the spending in Medicare passed by this body and then each year those cuts to try to restrain the spending on Medicare being passed.

One of two things is going to happen. Either these cuts in Medicare are going to take place, and it is going to cripple the program and particularly hurt it in a number of rural areas across the country and in my State, or these cuts will never take place in Medicare and it is going to add to a ballooning deficit and debt that is taking place right now. Either choice is an irresponsible choice for this body to do. It is irresponsible for this country.

Most people look at it and say: I want to get more people covered, and I want to bend down the cost curve. But let’s do that on an incremental basis.

Senator Kyl spoke about incremental changes that can take place, whether it is tort reform, allowing bigger pooling on health insurance, whether it is starting more community-based clinics, one that I look at as something that has worked in my State to get more people covered at an earlier age instead of what it does to their health care. All of those are incremental, low cost, and, in some cases, ones that actually do bend down the cost curve and that can help, not a gargantuan $2.5 trillion program that takes $500 billion out of Medicare that is already headed toward insolvency in less than a decade. The bill doesn’t make sense to individuals.

To do it on top of a time period when the President, 10 days ago, comes back from China, meeting with our bankers, as most people look at it, and the bankers lecturing us on why are we spending more money which we don’t have, going further and further into debt, at this point in time, being lectured by the Chinese when we ought to be talking to them about what they are doing about human rights and currency. We are being lectured about fiscal irresponsibility, and it is because of bills such as this. If we just stop and slow down and listen to seniors and others across this country, there is a commonsense middle ground that we can go to, that doesn’t cost anything along the nature of health care for most people but addresses the narrow problem of getting the cost curve down, of getting more people covered. This bill with these cuts in Medicare cripples many of my providers in the State of Kansas and will make them less—a hospital, keep the hospitals open, to try to provide doctors in the community—a lot of the hospitals are going to close and a lot of providers will stop providing Medicare—or, in all probability, these cuts will never happen, and it will be added to the debt and deficit, completely irresponsible toward our kids.

I urge my colleagues to vote for the McCain motion that makes sense, that is what the citizenry wants to do: send these cuts in Medicare back to communities and pull out of this bill.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Tennessee.

Mr. COOPER. How much time remains on our side?

The ACTING PRESIDENT pro tempore. There is 7 minutes 6 seconds.

Mr. CORKER. I thank the Chair.

Mr. President, I am glad to be on the floor of the Senate with the distinguished Senators from Kansas and Connecticut and Montana. We have obviously before us one of the most important issues we will deal with in this body.

I have had over 40 townhall-like meetings since the beginning of August. I can say without hesitation that I have never used those meetings to try to focus on some of the hot-button issues that divide us. On not one occasion have I tried to focus on the fundamentals of this health care bill. Way back when, when I began meeting with the distinguished chairman of the Finance Committee—I greatly appreciated his desire to meet with me—and realized that we have written down money that will be taken to leverage a new entitlement, I began expressing my concerns about that.

Later, I sent a letter to Majority Leader Reid, signed by 36 Senators, talking about the fact that if Medicare moneys were used to leverage a new entitlement, we could not support that effort.

The reason I say this is, this is the same exact thing I have been saying about this bill from day one, before it was ever constructed. I am very dismayed that we find ourselves here in December debating a bill that does exactly that.

When I first came to this body, there was a lot of concern about the solvency of Medicare. Everyone here knows the trustees have stated that in 2017 Medicare will be absolutely insolvent. Two Senators from opposite sides of the aisle have tried to create legislation that would put in place a commission, eight Republicans and eight Democrats, to actually solve that issue. We realize we do not have the resources in Medicare to actually deal with the liabilities we have with this program.

The fact is, the other piece of this that is extremely troubling is that we all know we have the issue of SDR, the doc fix, which is a colloquial term to describe the fact that in any year after this bill passes, physicians across the country will be receiving a 23 percent cut for serving Medicare recipients. Medicare recipients understand what means. It means they have less physicians to deal with their needs, they will have at that time. This bill, instead of dealing with that issue, deals with it for one year. What that means is there is about $250 billion worth of expenses that are not being dealt with in this Medicare savings.

Let me go walk it one more time. We have a program that is insolvent. We have a program that cannot meet the needs of those people who have paid into it for years and many of us concerned about what they will have at that time. This bill, instead of dealing with that issue, they will have dealt with in this Medicare savings.

We are going to kick the can down the road. We are going to cause physicians around the
country next year to, if this bill passes—if not, certainly they will be dealing with that this year—but we are going to cause physicians around the country another year to be concerned about these huge cuts, not deal with it in this bill, and add up with a $250 billion obligation that could have been dealt with during this health care reform that now is not met, that is going to create additional fiscal burdens to this country and certainly great anxiety to seniors and physicians who care for them.

I tried to stick with the basic fundamental building blocks of this bill. I don't think anybody in this body has ever heard me focus on some of the melodramatic things. The fact that we would use Medicare moneys to create a new entitlement, the fact that we would have an unfunded mandate to States through Medicaid of $25 billion, to me, is problematic; the fact that premiums are going to increase, whether it is the CBO number of 10 to 13 percent or the Oliver Wyman number in my State which says 60 percent, the fact that private premiums are going to go up and the fact that we are using 6 years of costs and 10-year worth of revenues—I don't know how we have gotten caught up in this debate in such a manner that we are ignoring basic fundamentals that I don't think any of us on our own accord would be supporting.

The fact is, I am afraid this, again, has become nothing but a political victory for the President. What I hope we will do is step back and do that in a bipartisan way that will stand the test of time. I ran on health care reform. I would like to see us do responsible health care reform. The basic fundamentals of this bill do not meet that test.

I yield the floor.

The Acting President pro tempore. The Senator from Connecticut is recognized.

Mr. DODD. Mr. President, how much time do we have?

The Acting President pro tempore. The Senator has 30 minutes.

Mr. DODD. Mr. President, let me first talk about the Medicare issue, because this has been the subject of sort of round-and-round debate, back and forth over the last couple of days. It is important to share, again, as emphatically as I know how what is being done with regard to Medicare. The whole idea is to strengthen Medicare, to put it on a sounder footing, to extend its solvency from 8 years by an additional 5 years, and making it a stronger, more reliable source of health care for older Americans.

In fact, the finest and largest organization representing older Americans, which doesn't lightly endorse proposals without examining them thoroughly—hardly a partisan group given the fact of where they have been on these issues—put out, once again, in the last 24 hours a statement laying out the facts of what is included in the bill drafted by the Finance Committee principally in this area of Medicare.

Let me recite, if I may, the facts as they identify them. Some of the health care reform proposals being considered by Congress would cut Medicare benefits or increase out-of-pocket costs for Medicare services. That is not from the Democratic National Committee. It is not from the HELP Committee or to the Finance Committee. This is from AARP saying: None of the proposals in this bill cut Medicare benefits or cut Medicare services.

Fact No. 2, the health care reform bill drafted by the Finance Committee will lower prescription drug costs for people in the Medicare Part D coverage gap, or the so-called doughnut hole with which many seniors are familiar. We are going to cut the cost of prescription drugs. This is not from some partisan group announcing what is in the bill. This is from an objective, nonpartisan analysis of the bill that is before us.

Fact No. 3, health care reform will protect seniors' access to their doctors and reduce the cost of preventive services so patients stay healthier. Again, that is critical. I presume others understand this; it is axiomatic you wonder why you have to explain it. It is better to catch a problem before it becomes a major problem. Through mammograms, colonoscopies, obviously examinations and screenings, you can discover that an individual has a problem and, if caught soon enough, address it. As many of my colleagues know because it became rather public, I went through cancer surgery in August. It was discovered that I had an elevated PSA test, indicating I had prostate cancer. That screening let me know that I had a growing problem that I had to deal with. So I went through a variety of discussions on what best to do, what was the best way to handle all of this and decided that surgery made the most sense.

The cost of that surgery is expensive. It is not cheap—$5,000, $6,000, $7,000, $8,000 to do it. If I had not discovered I had prostate cancer and it had grown, I could have become 1 of the 30,000 men a year in this country who die from it, or if I had waited longer for it to be full-blown cancer, I am told it could have easily cost $250,000. So by catching this early and getting the needed treatment, I was not only able to stay alive and stay healthier, with two young sons, ages 7 and 8—and looking forward to the day I may dance at their weddings—but also there were the savings because it did not grow into a problem that would require massive expenditures to deal with it.

Our bill deals with that. We provide for the first time ever that seniors and other Americans have access to prevention and screening tests that would allow all to detect problems if they have early on. That is according to AARP. That is what we drafted in this legislation. It is a major benefit.

I listened to our colleague from North Carolina yesterday, Senator Hagan, talk about nurses in a hospital in her State of North Carolina who were not getting mammograms early, not because they did not want them but because, of course, the out-of-pocket expenses for them are so high they could not afford to do it and pay rent and put food on the table and take care of their families.

That hospital in North Carolina decided they were no longer going to require their nurses to pay those high out-of-pocket expenses and they eliminated that. As an aside, or almost every nurse—in that hospital got those mammograms early on and, of course, could identify problems before they became larger issues for them to grapple with.

What of this bill of ours does. That is a major achievement—a major achievement. So the suggestion is, we ought to roll back and commit this bill. But that would eliminate the kind of investments we make in reducing the cost of prescription drugs or providing the kinds of benefits so people can get screenings and treat problems while they are still small.

As a Senator, I have a health care plan that allows me to do that. I am 1 of 8 million people in this country who are Federal employees. We all get to do that. Why should a Senator's battle with cancer be more important than someone else's in this country? Why shouldn't every American man over the age of 50 be able to be screened to determine whether they might have prostate cancer?

That is what we are talking about. That is what we are achieving in this bill. The idea that the status quo is OK is wrong. It is not OK. To say we ought to throw the bill back into committee, again—we all know what the meaning of that is, of course. It will mean an end to this legislation. Those are the facts.

Fact No. 4, if you will: Rather than weaken Medicare, the health care reform will strengthen the financial status of the Medicare Program. That is from AARP. That is not some partisan conclusion.

I say, respectfully, to our colleagues, and having been through this at great length over the summer, filling in for our friend whom we have now lost, Senator Kennedy, we went through long debates and discussions early on, a lot of bipartisan discussions. As I pointed out earlier, as to the bill that came out of the Health, Education, Labor, and Pensions Committee in the Senate, we conducted the longest
markup in the history of that committee, going back decades, in order to listen to each other and to try to provide a bipartisan bill.

In many ways, that bill is a bipartisan bill. It did not get bipartisan votes, coming out of the committee. But the substance of the legislation includes the ideas and thoughts of our colleagues across the political spectrum, and it is important the public know that during the debate.

This is not a bill that was rushed through, jammed through. My colleagues from Montana, Senator Baucus, spent weeks and weeks—months—with Democrats and Republicans gathered around the table late into the evenings talking about how we can shape this bill on a bipartisan basis. I attended many of those meetings in his office. No one can accuse the Senator from Montana of not reaching out to the other part of this solution. He went beyond the extra mile to achieve that, and he was flatly turned down, regrettably, in that effort. But that should not be a reason why we do not try to move forward.

I am still hoping we can get bipartisan support for the bill before it is concluded, but we will only get there if we work at it, and this is where we are working at it: on the floor of the Senate, and it is an opportunity to come forward and make constructive suggestions—not sending the bill back to committee, in effect, killing the legislation. That is the effect of what would happen if the McCain amendment were adopted.

Rather than engage in this kind of debate back and forth, where the Republicans say Medicare gets cut and the Democrats say, no, it does not, I wished to share with my colleagues this morning what nonpartisan, outside groups say about this bill. Listen to those who have made an analysis of this bill who do not wear a partisan hat, who do not have a political label attached to their names but are analyzing every syllable, every punctuation mark in the bill to determine what it does for people. The most important, significant organization that represents the interesting of the elderly in this country has analyzed this bill and has said to America: This is a good bill. This bill strengthens Medicare, provides benefits, and reduces costs.

That is what we have tried to achieve over these many months. So let’s move on. If you want to cut this bill, if you want to change all this, then offer an amendment and let’s vote on it, up or down, and move forward. I urge my colleagues to support this legislation and reject the McCain amendment because I think his proposal would do great damage to the effort we have achieved so far.

With that, I yield the floor.

The Acting President pro tempore. The Senator from Montana is recognized.

Mr. Baucus. Mr. President, I noted that the other side, in the last couple, 3 days, has tried to make the case that seniors’ Medicare benefits are in jeopardy because “this legislation cuts Medicare.” I have heard that statement over and over and over and over again. In fact, the last speaker on the other side made that same point. I am thoroughly surprised, when I hear those statements. Why am I very surprised? Because it is totally, patently false. It is false. It is untrue.

There are no benefits cut here, none. It is not true that the private plans, Medicare Advantage plans, which are vastly overpaid—the nonpartisan MedPAC organization states they are vastly overpaid by about 14 percent—one could say those private plans—it is not Medicare; those private plans, Medicare Advantage; those are not Medicare plans, those are private plans, private insurance plans—they may be overprescribing some non-guaranteed benefits for beneficiaries, things such as eyeglasses or something like that, but that is not true. That is true. But none of the guaranteed benefits—the basic benefits under Medicare that every senior knows about when he or she goes to the doctor; and it is care under Medicare—is reduced. None.

In fact, this legislation adds benefits to seniors. For example, it virtually fills up this thing we call the doughnut hole. That is the portion of prescription drug payments that seniors otherwise would have to pay $500 or $500 of that is going to be paid for, and the rest of it is going to be paid for at least for 1 more year. So that is an additional benefit. Then all the screening provisions that are in this bill, that is an additional benefit. There are many other benefits that are added onto the ordinary benefits seniors have.

So it is not true—it is not true—that the basic guaranteed benefits under Medicare are cut. None of the guaranteed benefits are cut. None. So it is totally untrue. It is false when people make the claim that “Medicare is being cut.”

They are being very clever, the people who are making those claims. What they are saying when they say Medicare will be cut—they want you to think they mean benefits will be cut—but deep in their mind, what they are saying, “We are holding back in their mind—well, when pressed, they will agree, well, it is the pharmaceutical companies; they are doing it.” But it is the medical equipment manufacturers; it is the pharmaceutical industry. That is being cut. That is “Medicare” that is being cut and, therefore, that will hurt seniors. That is kind of the way they get around it.

Well, the fact is, the way you preserve the solvency of the trust fund is to make sure there are not so many payments, frankly, by Uncle Sam going to pay for all the doctors and hospitals and so forth so the solvency of the trust fund is extended. Right now this legislation extends the solvency of the Medicare trust fund. If this legislation were not to pass, the Medicare trust fund would probably go insolvent in about the year 2017. But this legislation extends the solvency of the trust fund for at least 5 more years to 2022.

So I wish to make it very clear that this legislation we are considering does not cut Medicare benefits. In fact, the hospitals and docs, I would say, are going to find at least a 5-percent increase in growth over the next 10 years in payments to them under the Medicare Program—growth. I have a chart which I showed yesterday on the floor. It showed, for each of the various years, it is a 5-percent increase in growth for all those industries. They are being cut 1.5 percent, but that is from a 6.5-percent growth, to net down to a 5-percent growth for each of the years.

You ask analysts on Wall Street how hospitals are doing. They are doing great under this legislation. You ask analysts on Wall Street how the pharmaceutical industry is doing. They are doing great under this legislation. You ask any analyst about other industries—home health care, hospice care, you name it—they are all doing OK. Wall Street analysts say they are doing fine.

Why are they doing fine? Why, objectively, are they doing fine? Why do the CEOs of these organizations not grumble too much? Because they know what they may lose in a little bit of a reduction in their payments—they will still be making a lot of money. So they will make up in volume because so many more people will have health insurance. They know that. They are going to make a lot of money. So they are OK.

So it is not true that Medicare is going to go broke under this legislation. First of all, there is no reduction in benefits. That is very clear. Senator Dodd read a letter from AARP making that very clear. Also, the reductions are reductions in the rate of growth of provider payments; they are reductions in the rate of growth of provider payments, and they are going to do fine. Providers do not care that much because they are making it on volume because everybody is going to have health insurance. They have quite a bit—a 5-percent growth rate anyway. So it is not true—it is not true—that Medicare is in jeopardy because of this legislation. It is not true that benefits are going to be cut. In fact, just the opposite is true. This legislation strengthens benefits, increases benefits, extends the length of the Medicare trust fund to a future date further down the road, so it stays solvent for many years than otherwise is the case.

This legislation helps seniors. It helps seniors, contrary to what you are hearing on the other side that it hurts seniors. If you just look at the facts, not the rhetoric—not the rhetoric but just look at the facts, look at the facts and look at who the supporters of this legislation are and objective groups and what they say about this legislation—you cannot help but be compelled...
to the conclusion that this legislation is not only good for seniors, it is very good for seniors.

RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The Republican leader is recognized.

Mr. MCCONNELL. Mr. President, with the apologies to my good friends from Montana and Connecticut, I was unavoidably detained at the opening and would like to now, on my leader time, give my opening remarks.

The ACTING PRESIDENT pro tempore. The Senator has the floor.

AFGHANISTAN

Mr. MCCONNELL. Mr. President, the challenges of the ongoing war in Afghanistan are immense, but Americans believe in the mission. They trust the advice of our commanders in the field to see that mission through.

So I support the President’s decision to follow the advice of General Petraeus and General McChrystal in ordering the same kind of surge in Afghanistan that helped turn the tide in Iraq.

These additional forces will support a counterinsurgency strategy that will enable us to begin the difficult work of reversing the momentum of the Taliban and keeping it from power.

The President is right to follow the advice of the generals in increasing troops, and he is also right to focus on increasing the ability of the Afghan security forces so they can protect the people.

By doing both, he has made it possible for our forces to create the right conditions for Afghanistan—the right conditions for them to defend themselves, create a responsible government, and remain an ally in the war on terror.

Although our forces are in Afghanistan to defend our security interests, the people of Afghanistan must assume a greater burden in the future. The President’s plan recognizes that.

Once we achieve our objectives—an Afghanistan that can defend itself, govern itself, control its borders, and remain an ally in the war on terror—then we can reasonably discuss withdrawal, a withdrawal based on conditions, not arbitrary timelines.

But, for now, we owe it to the American people, to those who died on 9/11, and to the many brave Americans who have already died on distant battlefields in this long and difficult struggle, to make sure Afghanistan never again serves as a sanctuary for al Qaeda. We owe it to the men and women who are now deployed or who will soon be deployed to provide every resource they need to prevail.

HEALTH CARE REFORM

With every passing day, the American people become more and more perplexed about the Democratic plan for health care, and they like it less and less.

Americans thought reform meant lowering costs. This bill actually raises costs. Americans thought reform meant helping the economy. This bill actually makes it worse. Americans thought reform meant strengthening Medicare. This bill raids it to create a new government program that will have the same problems that Medicare does. Americans thought reform meant helping seniors. What they are getting is the opposite—more spending, more debt, more burdens on families and businesses already struggling to get by.

One of the biggest sources of money to pay for this experiment is Medicare. This bill cuts Medicare Advantage by $120 billion. It cuts hospitals by $135 billion. It cuts home health care by $42 billion. It cuts nursing homes by $15 billion. It cuts hospice by $8 billion. Reform shouldn’t come at the expense of seniors. The McCain amendment guarantees it wouldn’t.

The McCain amendment would send this bill back to the Finance Committee with instructions to remove the language that allows the McCain amendment. So I support the President’s decision to follow the advice of General Petraeus and General McChrystal in ordering the same kind of surge in Afghanistan that helped turn the tide in Iraq.

The McCain amendment also says any funds generated from rooting out waste, fraud, and abuse should be used to strengthen Medicare, not to create an entirely new government program.

A vote in favor of the McCain amendment is a vote to protect Medicare. Let me say that again. A vote in favor of the McCain amendment is a vote to protect Medicare. A vote against the McCain amendment is a vote to raid this vital program in order to create another one for an entirely new group of Americans. So a vote against the McCain amendment is a vote to take money out of Medicare to create a program for an entirely different set of Americans. A vote against the McCain amendment is a vote against our seniors, and it is a vote against real health care reform.

Mr. President, I yield the floor.

Mr. DODD. Mr. President, how much time remains?

The ACTING PRESIDENT pro tempore. There is 13 1/2 minutes.

Mr. DODD. I yield myself 5 minutes, if I may. I want to go back, if I can, I wish to put up these charts. Again, I say this respectfully, because I genuinely believe that people across the spectrum want to see some reform of the health care system. The question is whether the proposal that has been laid before us by the Finance Committee will have the needed reform and whether the ideas we bring to the table are actually going to achieve lower costs, provide greater access, and improve the quality of health care. We believe very firmly and strongly that it does.

There are outside observers of this process who have no political agenda whatsoever other than to make determinations as to whether the goals we have sought in this legislation achieve the desired results. It is the conclusion of those observers that make these determinations that, in fact, we have done exactly what we said we had set out to do.

But I wish to point out, because I think it is important when I hear the arguments from our friends on the other side about their deep concerns about Medicare, it is very important they understand that over the last 20 years, while the President, who has been exactly the opposite reaction when it comes to the Medicare Program in our Nation. Going back to 1995, when our friends took control of both this body and the other body, the then-Speaker of the House Newt Gingrich took the world that basically he was prepared to let Medicare “wither on the vine.” That is not ancient history. That is not 1965 when the Medicare Program was adopted; that is merely 14 years ago when the other party, for the first time in 40 years, became the dominant party here in Congress. One of the first statements from the leadership of that party was to let this program “wither on the vine.” Again, that is one person, the Speaker, the leader of the revolution that resulted in the results we achieved electorally in 1994. But I think it is important as a backdrop. When we hear the debate about Medicare, it is important to have some history about where the parties have been on this issue.

Generally speaking, in 1995 we begin with that as a backdrop.

In 1997, 2 years later, it happened again. In 1997, proposed Medicare cuts in the Republican Balanced Budget Act of that year were twice as much as the cuts that are so often described in this bill. They proposed a 12.4-percent reduction in Medicare benefits in 1997. Of course, the last budget submitted by President Bush last year—again, reflective of where things stand, and this is a year ago, not 14 years ago, and not 1997, but 2009—the Bush administration in its submission of this budget proposed a $481 billion reduction in Medicare benefits. That was not in the context of a health reform bill; that was in the context of a budget proposal.

Here we are talking about savings by reducing costs for hospitals and other providers as a way of strengthening Medicare, providing more benefits to the beneficiaries themselves through things such as prescription drugs as well as screenings and early prevention efforts which are included in our bill.

Those things have been identified, of course, by AARP and the National Committee to Preserve Social Security and Medicare. They have analyzed our proposals and have suggested we do just that. We strengthen Medicare and we preserve those benefits. Our bill saves $380 billion in order to strengthen the Medicare proposal. It improves the quality of health care for seniors as part of our comprehensive reform. In fact, Senator Coburn’s Patient Choice Act actually imposes $40 billion more in cuts to Medicare Advantage than our bill does.

I find it somewhat intriguing that those who are arguing for the Coburn proposal as an alternative and simultaneously suggesting we ought not to do anything to Medicare Advantage have
not read the Coburn bill, because he cuts $40 billion more out of Medicare Advantage than we did in our legislation as proposed.

In conclusion, let me quote from the National Committee to Preserve Social Security and Medicare—again, not a partisan organization. Their sole mission is to see to it that Social Security and Medicare will be there for the people it was intended to support. Let me quote exactly from a letter sent to every senator yesterday from the committee:

Not a single penny of the savings in the Senate bill—

the bill now before us—

will come out of the pockets of beneficiaries in the traditional Medicare program. The Medicare savings included in H.R. 3590, the Patient Protection and Affordable Care Act, will positively impact millions of Medicare beneficiaries by slowing the rate of increase in out-of-pocket costs and improving benefits, and it will extend the solvency of the Medicare trust fund by 5 years. To us, this is a win-win for seniors and the Medicare program.

So we can hear all of the partisan debate back and forth as to what this bill does, but if you are interested in what those organizations say, whose sole mission is to analyze whether beneficiaries are going to be advantaged or disadvantaged by what is being proposed here, they categorically, unequivocally, suggest that the McCain amendment does just the opposite of what our bill does. It would roll the clock back, damage seniors terribly by reducing or eliminating the provisions we have included in our bill, and they strongly support what the Finance Committee wrote in its bill that is now presented to all of us here as a way to strengthen and preserve the Medicare Program.

I say to my colleagues and to others, you can listen to this partisan debate back and forth as to whether you want to believe the Democrats or believe the Republicans, and I would suggest to you that you are not clear who to believe in this, listen to the organizations whose job it is to protect this program, with whom we have worked very closely to determine that we would not in any way reduce those guaranteed benefits that Senator BAUCUS addressed in his remarks. That is what we do. That is why this bill is a good bill and deserving of our support. I urge our colleagues to reject the McCain amendment.

Mr. President, yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, the Republican leader a few moments ago said this bill raises costs. With all due respect to my good friend from Kentucky, that statement is false.

Just this week, the nonpartisan Congressional Budget Office, the organization that analyzes legislation—and both sides, both bodies depend on it; it is a professional outfit, I might add—said our bill would reduce premiums, not increase but reduce premiums for 93 percent of Americans. And for all Americans, it would make sure that better quality insurance is available.

Let me state that a little bit differently. The Congressional Budget Office said that for 93 percent of Americans, premiums would be reduced. It is true that for 7 percent that is not the case. Those are Americans whose incomes are too high to qualify for subsidies; that is, the tax credits, buying insurance in exchange. But those 7 percent would instead have a lot higher quality insurance than they get today because of the insurance market reforms that are in this legislation. The provisions prevent insurance companies from denying coverage based on preexisting conditions, health status, the committee market rating provisions, no rescissions, etc, cetera. So for all Americans, it is true that this legislation will provide better quality insurance comparing apples with apples. There is a reduction for 93 percent of Americans, and 7 percent would be in the individual market and they would have a lot higher quality insurance. So if the quality is much higher, it would exceed the increase in premiums. They would be getting a better deal than they would otherwise be getting.

CBO looked at this for the year 2016. They didn’t look at it for other years, but at least that is the case for 2016: a reduction, not an increase but a reduction. In fact, for many in the nongroup market, those who individually buy insurance, they would find their premiums would be reduced about 40 or 50 percent. About 60 percent of those in the nongroup market are finding their insurance premiums would be reduced.

I don’t have the exact figure in front of me, but it is in the neighborhood of a 40- or 50-percent reduction in premiums. That is due to tax credits. Again, CBO says those tax credits would cover nearly two-thirds of premiums. That is a tax credit. Again, CBO says those tax credits would cover nearly two-thirds of premiums.

CBO said those getting these tax credits would pay for roughly 56 percent to 59 percent lower premiums than they would without our bill. Those are real savings. That is with respect to the premiums.

What about out-of-pocket costs? This legislation has absolute limits on out-of-pocket costs. Today insurance companies can sell you a policy, you pay certain premiums, but there is no limit on the out-of-pocket costs you might have to pay. Your deductible is so high, for example. This legislation puts an absolute limit so no policy can be sold that allows you to have out-of-pocket costs above a certain amount. I think it is $6,000 for an individual, and it might be double that for a family. But there is a limit. So this bill does not, as stated by the Republican leader, raise costs. In fact, it reduces costs.

In addition, there are many people who say, Oh, gosh, this is a $1 trillion bill. Some people even say it is a $2.5 trillion bill. Senators on the other side of the aisle make those statements and they say this to try to scare us.

I will be honest with you. I don’t know if they believe it. They like saying it because it is a scare tactic. I say I am not sure they believe it. I wonder if they believe it, because when you read the legislation, it is deficit neutral. It does not add to the deficit.

We have a budget resolution. Under that budget resolution, health care legislation for the next 10 years has to be deficit neutral. It cannot add one thin dime to the deficit. So I am a little curious about people who call it a trillion bill. In fact, it reduces the deficit by $130 billion over a 10-year period. That is what the Congressional Budget Office says, the professional nonpartisan budget office.

Just this week, the nonpartisan Congressional Budget Office, the CBO says our bill reduces the deficit by a one-quarter of 1 percent of the gross domestic product. That is roughly $½ trillion. In the second 10 years, this legislation reduces the deficit by $½ trillion. It is a reduction in the deficit.

I don’t know why these people are saying on the other side that this is a trillion-dollar bill. One said—and I will not mention his name—the other day that this is a $2.5 trillion bill. That is not true. It is just not true because it is paid for. It would only be fair for them to say it is paid for. I think it is fair to get both sides of the story, not just one side. It does cost $1 trillion over 10 years, but it is more than paid for over 10 years. Those who say $2.5 trillion—they start at 2014 up to 2020, and say that is why it costs so much. It is paid for during those years, too.

Let me make it very clear this bill doesn’t raise costs. In fact, it lowers costs, and the CBO says so. It doesn’t add to the Federal deficit. In fact, it reduces the Federal deficit. I urge everyone to look at the facts closely whenever we hear statements made by anybody including me. I urge you to listen to the words and see what is really going on. Like my father used to say: Don’t believe everything you read and only half of what you hear. Take everything with a few grains of salt.

The PRESIDING OFFICER (Mr. KIRK). The Senator from Tennessee is recognized.

Mr. ALEXANDER. Mr. President, I agree with the Senator. That is why we have 22 minutes on the Republican side to clear up some misconceptions.

The Democratic health care bill does cost $2.5 trillion over 10 years when it is fully implemented. If I may say so, it is a lie and a lie to say that people couldn’t figure out the difference between the first 10 years, when the bill wasn’t implemented in 4 of those years, and they would like to know that it costs $2.5 trillion.

Mr. BAUCUS. Will the Senator yield for a question?

Mr. ALEXANDER. If it is on your time.
Mr. BAUCUS. Is it paid for?
Mr. ALEXANDER. The Senator is right. It is paid for by cutting grandma’s Medicare. It is paid for by cutting grandma’s Medicare by $465 billion over a 10-year period of time, and about $500 billion in taxes.
Mr. BAUCUS. That is a second question I would love to debate with the Senator. But on the first question only, the Senator admits it is paid for?
Mr. ALEXANDER. No. I admit it costs $2.5 trillion, and the attempt to pay for it is through Medicare cuts, tax increases, and increases in the deficit by not including the physician reimbursement in the health care bill.
Mr. BAUCUS. One more question. I think we all know the House has taken action on physician reimbursement, and the Senate will also do so before we adjourn. That is the so-called doc fix. That is a separate issue. That will be paid for. Putting the doctor issue aside, health care reform—and I say that because we take up the doc fix virtually every year. We don’t take up health care reform every year. That is an entirely separate proposition, separate legislative endeavor.
If the Senator will bear with me and take the table for a second—we can address that later—health care reform—to a 10-year number, or when you start in 2010 or in 2014, wherever you are starting—either there is $1 trillion or $2.5 trillion, depending on when you start, not getting into how it is paid for. Is it paid for and therefore it is not deficit; am I not correct?
Mr. ALEXANDER. I will concede to the Senator from Montana that the attempt of the Democrats to pay for this $2.5 trillion bill consists of Medicare cuts, tax increases, and additions to the deficit by not including the physician reimbursement, which is an essential part of any 10-year health care plan. There may be other problems, but those are the three things I know about.
Mr. BAUCUS. One more question on my time. Is it true there are no cuts in guaranteed beneficiary payments—one whatsoever—in this legislation—in guaranteed benefits?
Mr. ALEXANDER. I would say no to that. Mr. President, because the Director of the Congressional Budget Office made it clear there would be specific cuts for those who are in Medicare Advantage, which is about one out of four seniors.
Mr. BAUCUS. Is it true those provisions are not guaranteed provisions? I am talking about guaranteed benefits that seniors expect to get when they go to the doctor, fee for service, expected benefits, under ordinary Medicare, not benefits that a private plan may pay in addition.
Mr. ALEXANDER. Mr. President, it is clear there are other cuts in Medicare. The Chair and the Senator from Montana and the Senator from Connecticut have all agreed that is a big part of how the bill is supposedly paid for. It is specific enough to say that $135 billion comes from hospitals; $120 billion from Medicare Advantage, which 11 million seniors have; nearly $15 billion from nursing homes; $40 billion from home health agencies; $8 billion from hospices.
The Director of the CBO testified that provisions like that would result in specific cuts to benefits for Medicare Advantage. He said that fully half of the benefits currently provided to seniors under Medicare Advantage would disappear. The changes reduce the extra benefits, such as dental, vision, and hearing coverage, that currently are made available to beneficiaries.
Mr. BAUCUS. One more question. Does the Senator agree this legislation will extend the solvency of the Medicare trust fund for 5 years, and failure to pass this would mean the solvency of the Medicare trust fund would not be extended for 5 years?
Mr. ALEXANDER. I wholeheartedly disagree with that. The Medicare trustees have said that between 2015 and 2017 Medicare will be approaching insolvency. They have asked that we take urgent action. The urgent action recommends that is what we take $465 billion out of the Medicare Program over 10 years and spend it on a new entitlement.
It is hard for me to understand how that can make Medicare more solvent, and then you wait 4 years before any of the benefits are then extended to the beneficiaries? That, on its face, is a remarkable piece of legislation, experience, which has only been 20-some years, is that we haven’t passed legislation that says we are going to collect taxes on it for 4 years, and then we are going to give you whatever benefits that may accrue from this legislation. Again, there has been no time in history where we have taken money from an already falling system to create a new entitlement program.
Mr. BAUCUS. Which colleague is the Senator for Arizona?—I ask the Senator from Arizona—Will the Senator yield?
Mr. ALEXANDER. Yes.
Mr. McCaIN. Isn’t it, shall we say, Enron accounting when you have a proposal that, as soon as the bill becomes law, you begin to raise taxes and cut benefits, and then you wait 4 years before any of the benefits are then extended to the beneficiaries? That, on its face, is a remarkable piece of legislation, experience, which has only been 20-some years, is that we haven’t passed legislation that means we are going to collect taxes on it for 4 years, and then we are going to give you whatever benefits that may accrue from this legislation. Again, there has been no time in history where we have taken money from an already falling system to create a new entitlement program.
Mr. McCaIN. He does.
Mr. McCaIN. I believe the Senator from Tennessee has the floor.
Mr. ALEXANDER. I say to the Senator from Arizona that he is exactly right. Another way to describe it, the Senator from Kansas said it was like writing a big check on an overdraft bank account and buying a big new car.
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Mr. ALEXANDER. I say to the Senator from Arizona that he is exactly right. Another way to describe it, the Senator from Kansas said it was like writing a big check on an overdraft bank account and buying a big new car.
What did Senator BAUCUS say? He said: 
And above all, we must not use Medicare as a piggy bank.

What are we using the $483 billion in cuts in Medicare for? 
Then he said: 
That was a profound statement. Perhaps some changes lie ahead. But if they do, they should be made for the single purpose of keeping Medicare services for senior citizens and people with disabilities.

Isn’t it true that now that we are taking $483 billion out of a failing system the Medicare trustees say is going to bankrupt, and the Senator from Montana, 14 years ago, said: 
Seniors could easily be forced to give up their doctor, as doctors begin to refuse Medicare patients and hospitals—especially rural hospitals—close.

Isn’t that the effect of taking $483 billion in cuts in Medicare? Then the Senator from Montana went on to say: 
Equivalent to blowing up the house and erecting a tent where it used to be. 
Instead of blowing up a pup tent, I would say what they are doing is like a hydrogen bomb. Finally, Senator BAUCUS said: 
Staggering. The leadership now proposes something like $356 billion in Medicare cuts. It is staggering. It is a reduction of nearly a quarter in Medicare services by the year 2002.

All of us here learn about the issues. Apparently, the Senator from Montana didn’t learn much, because he was deeply concerned 14 years ago about a very small savings in Medicare. Now he wants to spend $2.5 trillion and taking $483 billion out of Medicare to create a new entitlement system.

Mr. ALEXANDER. Might I respond to the Senator?

Mr. ALEXANDER. Mr. President, I am happy to see a debate actually break out on the Senate floor on this issue.

Mr. BAUCUS. Here is your opportunity; here is your chance.

Mr. ALEXANDER. As long as it is on Democratic time.

Mr. BAUCUS. It is on both sides. We have even time.

Mr. ALEXANDER. I mean whatever time the Senator uses should be on Democratic time.

Mr. BAUCUS. Yes. The basic question, obviously, is how to protect Medicare benefits. I think most of us would say that is the basic concern. It extends the solvency of the Medicare trust fund. I think we would all agree that excessive payments to providers would cause insolvency of the trust funds to come earlier rather than later. We all agree with that proposition.

The next question is, What would excessive payments to providers be? Do providers get paid excessively? I think that is an honest question we should ask ourselves in a way to help extend the solvency of the Medicare trust fund. In fact, in 1995, many Senators, especially on the other side of the aisle, did say just that, that we have to cut Medicare in order to save benefits. That was made by many Senators. I have them right in front of me, if anybody wants to hear them. I am not going to go through all of that, but it is the truth. That is exactly what we are doing in this bill. We are trying to help extend the solvency of the Medicare trust fund by cutting down on excessive provider payments from the Medicare trust fund.

How do we decide whether payments are excessive? That is the basic question here. All we can do is just give our best shot, make our best judgment. I think it makes sense to look at the recommendations by outside independent groups, what they think. One is MedPAC, the Medicare Payment Advisory Commission. That is an outside group, as we all know, and that advises Congress on Medicare payments. As Members of Congress, we are not totally competent to know exactly what dollars should go to which industry group. Other groups, other obligations to think about. As Senators, we must be responsible to do the best we can. MedPAC has said these groups have been overpaid. And Wall Street analysts tend to agree. In fact, MedPAC said, with respect to Medicare Advantage, that they have been overpaid—I forget the exact amount but much less than the $118 billion reduction in this bill.

In fact, I totaled up and looked at the proposals, Medi- care hospitals, nursing homes, home health, hospice, PhRMA, you name it—and on average their growth rate over the next decade is going to be 6½ percent. That is the growth rate of providers. We decided to trim that a little bit by 1.5 percent. So it is 5 percent. It is a 5-percent growth rate in an attempt to try to find the right levels of reimbursement to providers, which will also help extend the solvency of the Medicare trust fund.

When we talk to providers, they basically agree with those cuts. They basically agree. Why do they basically agree? They basically agree because they know that with much more coverage, with so many people having health insurance, they could spread out their business. They may lose a little on margin, but they can pick it up on volume. That is exactly what their business plan is under this bill.

Wall Street analysts say—I quote them—these guys are doing great, they are doing well under this bill. They are not getting hurt. So we do achieve a win-win—I don’t like that phrase, by the way, but I will use it here—where the solvency of the trust fund is being extended and where reimbursement rates to providers are fair—not being hurt; it is fair. And that is why they want this bill, by and large. Most groups tend to want this bill enacted because they know it is good for the company, for the seniors, and it is good for them too.

Mr. MCCAIN. Mr. President, may I just mention again, $70 billion in fraud, abuse, and waste, and Senator COBURN, the doctor, can tell you, that is nowhere in this bill. The fact is, maybe some of the providers have been bought off, jowboned, or had their arms twisted or given a good deal, like PhRMA has. Recipients have it. Medicare recipients, if you can, cannot get it $483 billion without ultimately affecting their benefits, and that is a fact.

Again, conspicuous by its absence, I say to the Senator from Montana, totally conspicuous by its absence is any meaningful malpractice reform, which has been proven in the State of Texas and other States to reduce costs and to increase the supply of physicians and caregivers. There is nothing in this bill that is meaningful about medical malpractice reform.

I had a townhall meeting with doctors in my State, and everyone stood up and said: I practice defensive medicine because I fear being sued.

If you are really serious, I say to the Senator from Montana, if you are really serious about this, medical malpractice should be a key and integral part of it. Even the CBO costed it out at about $54 billion a year. When you count in all the defensive medicine, it could be as much as $200 billion over 10 years. That is conspicuous by its absence. I think it brings into question the dedication of really reducing health care costs across America.

Mr. ALEXANDER. Mr. President, we have a physician on the Senate floor, the Senator from Montana, who is a physician—and above all, we must not use Medicare as a piggy bank.

Mr. BAUCUS. No, no, no, I did not. With all due respect, I did not say that.

Mr. ALEXANDER. Didn’t I hear the words “providers overpaid”? I said about hospitals. I did not talk about doctors overpaid. If I may say to my friend from Tennessee, this legislation pays more to primary care doctors, a 10-percent increase in Medicare reimbursement for each of the next 5 years. I did not say “doctors.”

Mr. ALEXANDER. I must have misunderstood. Normally when we talk about providers, we talk about hospitals and physicians.

If we have a physician on the Senate floor, the Senator from Oklahoma, I wonder if he, having heard this debate, might want to comment. I might say, isn’t it true that the McCain motion, which we have on the floor, would send this back to the Finance Committee and say, if there are sitcoms, let’s spend it on Medicare to actually strengthen it?

Mr. COBURN. Mr. President, I thank the Senator. The first comment I have is about relying on what Wall Street analysts say today. They have about this much credibility in this country today. Look at the economic situation we find ourselves in because of what
Wall Street analysts have said that is the first point I would make.

The second point is that the majority whip yesterday said we should cut Medicare Advantage because of the 14 percent. Senator Dodd just recently went after the Patients’ Choice Act because we actually make it be competitively bid without any reduction in benefits. Your bill, for every Medicare Advantage, cuts 50 percent of the benefits that are offered.

The difference is—and I agree with the majority whip—we do need to have the savings in Medicare Advantage, but the way you get that is through competitively bidding it while at the same time maintaining the requirements for the benefits that are offered. There is a big difference in those two. Ours ends up being pure savings to save Medicare. The savings in this bill are to create a new entitlement.

The other point I wish to make is, if you are a senior out there listening and if you are going to be subject to the new increase in Medicare tax, for the first time in history, we are going to take this Medicare tax and not use it for Medicare, we are going to use it for something else under this bill. This one-half of 1 percent is now going to be consumed in something outside of Medicare. So no longer do we have a Medicare tax for the Medicare trust fund. We have a Medicare tax that funds the Medicare trust fund plus other programs.

I say to my colleagues, I think we want a little bit of the same thing. How do you go about it—the Senator from Montana recognized the fact that we are going to increase payments to primary care physicians. Ask yourself the question why only 1 in 50 doctors last year who graduated from medical school is going into primary care. Why do you think that is? Could it be that the government that is setting the payment rates created a maldistribution in remuneration to primary care physicians; therefore, we are choosing to go where there is money? You make 200 percent more over their lifetime by spending 1 additional year in residency rather than doing primary care?

What this bill does, and what the Senator from Arizona is trying to do by sending this bill back, is to refocus on the fact that Medicare money ought to be used for Medicare. If, in fact, we are going to slow the growth of Medicare, can we do that without cutting individual patient’s care? How do you prevent the growth in this bill for 11 million Americans who now have Medicare Advantage will diminish their benefits. That is out of the $120 billion that is going to come.

You cannot tell a senior who is in a rural part of this country, who affords Medicare Advantage to equalize their care with somebody who can afford a Medicare supplemental policy, you cannot tell them this is not going to diminish their benefits and their care, because it is. And in the bill, it actually states that it is going to decrease their benefits.

Mr. MCCAIN. Will the Senator yield?

Very briefly, the Senator from Montana talked about the support the bill gets. AARP makes more money from Medigap plans they sell to seniors. AARP should be opposing the bill, but other groups such as 60 Plus are educating seniors.

The AMA endorsement of the bill—shocking. The bill puts the government in charge, but AMA cut a deal to get their Medicare payments addressed by increasing the deficit by $250 billion.

Mr. COBURN. The Senator from Arizona—will the Senator yield for a minute?

Mr. MCCAIN. PhRMA—my God, if there ever was an obscene alliance made that will harm seniors because it has the administration against drug re-importation from Canada and competition for treatment of Medicare patients.

So now we understand a little bit better why these special interest groups, 500-some that have visited the White House in recent months, according to White House logs.

Mr. COBURN. The Senator would probably be interested in—and, I know, my colleagues on the other side—that the American Medical Association now has more than 10 percent of the actively practicing physicians in this country. The physicians as a whole in this country are adamantly opposed to this bill. The reason they are opposed to this bill is because you are insinuating government between them and their patient. That is why they are opposed to this bill.

So you have the endorsement of the AMA which represents less than 10 percent of the practicing doctors—actively practicing doctors—in this country because not only will it increase payments, but CPT code revenue is protected. That is the revenue AMA gathers from the payment system that continues to be fostered in this bill, which is their main source of revenue.

Mr. MCCAIN. May I ask my colleague’s indulgence for just a moment because, as you know, the majority leader seems to appear more and more frantic as he, perhaps, is reading the same polls we are that more and more Americans, when they figure out this legislation, are becoming more and more opposed to it.

Yesterday, the majority leader came out and directly addressed me, saying: ‘‘22 percent of the cost of Medicare is our Medicare Advantage program and get lower quality care.''

Yesterday, the majority leader came out and directly addressed me, saying: ‘‘22 percent of the cost of Medicare is our Medicare Advantage program and get lower quality care.''

Mr. President, I hate, I say to my colleagues, I think we have the endorsement of the largest association in the country—American Nurses Association—equally divided on this matter. The reason the nurses are opposed to this bill is because they believe that the savings in Medicare Advantage, but cut in benefits. Not true.

Mr. COBURN. The Senator from Arizona—will the Senator yield for a minute?

Mr. MCCAIN. PHI—Mr. President, will the Senator yield?

Mr. MCCAIN. Mr. President, I ask unanimous consent to have printed in the RECORD the entire FactCheck.org article.

Mr. MCCAIN. This man talks about earmarks, but his policy director states unequivocally that no benefit cuts are envisioned.

Mr. President, I ask unanimous consent to have printed in the RECORD the entire FactCheck.org article.

Mr. MCCAIN. As you know, there being no objection, the material was ordered to be printed in the RECORD, as follows:

OBAMA’S FALSE MEDICARE CLAIM SUMMARY

In a TV ad and in speeches, Obama is making bogus claims that McCain plans to cut $880 billion from Medicare spending and to reduce benefits.

A TV spot says McCain’s plan would bring about a 22 percent cut in benefits.

FactCheck.org says:

These claims are false, and based on a single newspaper report that says no such one-sided, partisan summary of a false reading of a single Wall Street Journal story, amplified by a one-sided, partisan
analysis that piles speculation atop misinterpretation. The Journal story in turn was based on an interview with McCain adviser Holtz-Eakin. He said flatly in a conference call after the ad was released, "No service is being reduced. Every beneficiary will in the future receive exactly the benefits that they have been promised from the beginning."

TWISTING FACTS TO SCARE SENIORS

Here’s how Democrats cooked up their bogus $802 billion claim. On October 6, the Journal ran a story saying that McCain planned to pay for his health care plan “in part” through reduced Medicare and Medicaid spending, quoting Holtz-Eakin. The Journal characterizes these reductions as both “cuts” and “savings.” Importantly, Holtz-Eakin did not say that any benefits would be cut, and the one direct quote from him in the article makes clear that he’s talking about economies:

Wall Street Journal, Oct. 6: Mr. Holtz-Eakin said the Medicare and Medicaid changes would improve the programs and eliminate fraud, but he didn’t detail where the cuts would come from. “It’s about giving them back all the package that has been promised to them by law at lower cost,” he said.

Holtz-Eakin complains that the Journal story was “a terrible characterization” of McCain’s intentions, but even so it clearly quoted him as saying McCain planned on “giving Medicare and Medicaid beneficiaries the benefit package that has been promised.”

Nevertheless, a Democratic-leaning group quickly twisted his quotes into a report with a headline stating that the McCain plan “requires deep benefit and eligibility cuts in Medicare and Medicaid”—the opposite of what Holtz-Eakin was saying. The report was issued by the Center for American Progress Action Fund, headed by John D. Podesta, former chief of staff to Democratic President Bill Clinton. The report’s authors are a former Clinton administration official, a former aide to Democratic Sen. Bob Kerrey and a former aide to Democratic Sen. Barbara Mikulski.

The first sentence said—quite incorrectly—that McCain “disclosed this week that he would force seniors from Medicare and Medicaid to pay for his health care plan.” McCain said no such thing, and neither did Holtz-Eakin. The Journal reporter cited a $1.3 trillion estimate of the amount McCain would save over 10 years, to make his health care plan “budget neutral,” as he promises to do. The estimate comes not from McCain, but from the Urban-Brookings Tax Policy Center. McCain and Holtz-Eakin haven’t disputed that figure, but they haven’t endorsed it either.

Nevertheless, the report assumes McCain would divide $1.3 trillion in “cuts” proportionately between the two programs, and comes up with this: The McCain plan will cut $582 billion from Medicare spending, roughly 13 percent of Medicare’s projected spending over a 10-year period. And with such a cut, the report concludes, Medicare spending will not keep pace with inflation and enrollment growth—thereby requiring cuts in benefits, eligibility, or both. "The Obama campaign began the Medicare assault with a 30-second TV ad released Oct. 17, which it said would run “across the country in key states.”

ANNOUNCEMENT: John McCain’s health care plan . . . first we learned he’s going to tax health care benefits to pay for part of it.

Now the Wall Street Journal reports John McCain . . . tax Medicare beneficiaries . . . cut Medicare. We Can’t Afford John McCain.

The ad quotes the Wall Street Journal as saying McCain would pay for his health care plan with “major reductions to Medicare and Medicaid,” which the ad says would total $802 billion from Medicare alone—“requiring cuts in benefits, eligibility, or both.”

Obama elaborated on the theme Oct. 18 in a stump speech in St. Louis, Mo., claiming flatly that “McCain faces a straight face major medical hardships under McCain:”

Obama, Oct. 18: But it turns out, Senator McCain would pay for part of his plan by making drastic cuts in Medicare—$882 billion worth. Under his plan, if you count on Medicare, you would have fewer places to get care, and less freedom to choose your doctors. You will pay more for your drugs, receive fewer services, and get lower quality care.

Update, Oct. 21: A second and even more misleading Obama ad begins: “How will your Medicare? It states flatly that McCain’s plan would mean a 22 percent cut in benefits, higher premiums, higher co-pays, . . .

Mr. MCCAIN. Mr. President, I hope the Senator from Nevada will stop making false claims—repeating the false claims that were in attack ads on me throughout the campaign, funded by tens of millions of dollars, about my positions on health care in America which the fact checkers found to be totally false.

As the narrator says that McCain’s plan “means a 22 percent cut in benefits,” the ad displays a footnote citing an Oct. 6 Wall Street Journal story as its authority.

FactCheck:
But, in fact, the Journal story makes no mention of any 22 percent reduction, or any reduction at all.

I hope, among other things, in his majesty, May I describe, frustration, that the Senate majority leader would at least mention of any 22 percent reduction, or any reduction at all.

I hope, among other things, in his majesty, May I describe, frustration, that the Senator from Nebraska . . . . . . . . .

Mr. MCCAIN. Mr. President, I hope the Senator from Nevada will stop making false claims—repeating the false claims that were in attack ads on me throughout the campaign, funded by tens of millions of dollars, about my positions on health care in America which the fact checkers found to be totally false.

And I hope that maybe, instead of attacking David Broder, instead of attacking me, instead of attacking others who are in support of this amendment, maybe we could have a more meaningful discussion about the facts surrounding this legislation.

Mr. DODD. Mr. President, may I inquire how much time remains on both sides?

The PRESIDING OFFICER. Thirty seconds remains for the minority.

Mr. DODD. The minority has 30 seconds.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. JOHANNS. Mr. President, I will speak very quickly, since we have 30 seconds.

Reality does set in. We have looked at the impact of these cuts on our nursing home beds in Nebraska. We have about 14,000 beds dedicated to our Medicare patients. This will be a loss of $663 per bed.

Mr. JOHANNS. Mr. President, I thank the Senator. That is very kind of you, and I appreciate that.

Maybe it comes from my time as Governor, maybe it comes from my time as mayor, but somehow, some people have to have legisla-

tion that is passed, whether it is by the Federal Government, whether it is at the State level or whatever. You can bounce this back and forth all day, but the reality is these are real cuts and they will involve real people that inv-

olve real people in our States. You can describe them any way you want, you can call them excessive payments, you can do this, that, or the next thing. You can say: Well, we are giving this our best shot, but the difficulty is this is a high-risk venture. We will be impacting in my State, for example—and every Senator could stand up and give this same speech—but this will impact the most vulnerable population in our Nation—people who are in a nursing home and who are the Medi-

care beneficiaries.

As I said in my short statement, there are 14,061 nursing home beds across our State that are dedicated to Medicare patients. We are working overtime to try to understand what this legislation does to real people. The number we have come up with, working with our nursing home industry, is that if this legislation is passed, each bed is impacted by a loss of $663.

I will sum up my comments by reading something that was sent to me by someone who works in the nursing home industry. Here is what this per-

son says:

For the first time in my career, I am honestly questioning how much longer I can continue. To constantly be up against regu-

lation and funding, when all you want to do is make a difference in someone’s life, is exhaus-

This is a high-risk venture. This shouldn’t be about taking our best shot, this should be about getting this legislation right.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Mr. President, let me, if I can, address a couple of points. First of all, I made this point the other day, but it deserves being made again because the suggestion somehow that this bill doesn’t provide any benefits to anyone until the year 2014 is untrue. I could spend the next 40 minutes describing the various things our bill does imme-

diately. Upon the enactment of this legislation, there are tax breaks immedi-

ately for small businesses to be able to reduce the cost of health care in a market where small businesses pay, on average, 16 percent more for health care than larger businesses do. As pointed out by the CBO, under our bill you are actually seeing pre-

mium cost reductions in the small
business market, as well as the individual market and the large-group market.

Right away our legislation closes a good part of that doughnut hole, which is an immediate benefit to the cost of prescription drugs for the elderly. That doesn’t happen 4 or 5 years from now, but immediately.

We provide immediate screening and prevention services for Americans. As I mentioned earlier, that is not only the humane thing to do, it is also a great cost saver. If you can detect an early problem and deal with it, the cost savings are monumental, and we all know that.

Under our health care plans as Senators—where we get 23 different options every year to choose from—we have that benefit. I am a beneficiary of that benefit, having identified a health care problem early through screening. That was not only beneficial to me personally, because I am going to be alive for a longer period of time otherwise, but it saved thousands of dollars in long-term medical costs that would have occurred if I had not identified the problem. Those are simple things that are included in our bill that happen immediately.

You can’t be dropped by your health care carrier, as you are today. Today, you can be dropped for no cause—for no reason whatsoever. That is stopped immediately on the adoption of this legislation.

So when I heard my good friend from Arizona saying there are no benefits in this bill for 4 or 5 years, that is not true. And again, a simple reading of the legislation would identify any number—I have here a long list—of the legislation would identify any number—I have here a long list—of the benefits that will happen immediately.

The issue Senator Baucus has raised over and over again is the issue of guaranteed benefits under Medicare. Guaranteed benefits. Let me challenge my colleagues to identify a single guaranteed benefit under Medicare that is cut by the bill before us. There is not a single benefit under the guaranteed program that is in any way disadvantaged or reduced as a result of this legislation. What is cut are private health care plans under the Medicare Advantage Program. The reason why we are doing this is Medicare Advantage overpayments cost every senior more money. A typical elderly couple pays an average of almost $1,000 per year in Part B premiums to pay for the Medicare Advantage overpayments, even if they are not enrolled in these plans. That is $90, on average, for every couple, and they get none of the benefits from it. Fully 78 percent of beneficiaries are forced to pay higher premiums for non-Medicare extra benefits they will never see.

Again, I understand some people would like to have those additional benefits. I understand that. They are not guaranteed Medicare benefits. These are benefits that are provided for under Medicare Advantage. But 78 percent of our elderly are paying higher premiums so a smaller percentage of people can get those benefits. Why should 78 percent of the elderly in this country pay a higher premium for a smaller percentage of people under private health care plans?

What Senator Baucus and the Finance Committee are doing is to reduce those costs. There are not guaranteed Medicare benefits. There is no guaranteed Medicare benefit that is cut under this bill, and I defy any Member of this body to find one guaranteed benefit that is reduced under this plan.

Mr. BURR. Will the Senator yield for a question?

Mr. DODD. I will be happy to yield to my friend.

Mr. BURR. I would ask the distinguished Senator from Connecticut if we empower the independent Medicare advisory board to come up with $23.4 billion in cuts under Medicare? Can the Senator from Connecticut assure me that the independent Medicare advisory board would not find a benefit that is under Medicare Advantage?

Mr. DODD. Absolutely. That is not allowed under this. You cannot cut guaranteed benefits. Going back and looking at providers—

Mr. BURR. If the Senator will yield for an additional question: Is this board empowered to find $23.4 billion worth of cuts?

Mr. DODD. Not under guaranteed benefits. That is very clear.

Mr. BURR. Will the Senator show me that language?

Mr. DODD. The board is prohibited, forbidden, from proposing changes that would take benefits away from seniors or increase their costs. The board cannot ration care, raise taxes on Part B premiums, or change Medicare benefits eligibility or cost-sharing standards.

It couldn’t be more clear. They are absolutely prohibited from doing that. And that is the point we have been trying to make, frankly. As we know, there are hospitals that will tell you themselves, in many cases, as a provider, there are cost savings there. I am told—and again my colleagues know more about these details than I do—that it is not uncommon for an elderly person to leave a hospital and, on average, be given four prescription drugs to take. I am told as well that within a month or so that elderly person is not following their prescriptions very well—either they live alone, or for one reason or another they do not follow their prescriptions—and they end up being readmitted. There is a very high readmission rate in hospitals, thus raising the cost for hospitalization.

Our bill makes significant efforts to try to reduce the problem of hospital readmissions, which, again, raises costs tremendously. That is where the savings are coming from here, by taking steps to try and reduce the readmission rate to the hospitals. That is a cost saving that is not denying a benefit to the elderly. It is trying to save money and save lives. That is what we are trying to achieve here.

But, again, I challenge any Member to come up and identify a single guaranteed benefit under Medicare that is cut in this bill. There are none. And 78 percent of our elderly should not be required to pay additional premiums to take care of a handful of other people other Medicare beneficiaries for the benefit they never get.

Mr. DODD. Will the Senator yield for a question?

Mr. DODD. I would be happy to yield to my colleague.

Mr. DURBIN. It is interesting to me that under the McCain amendment, the first line in the amendment—the motion to commit—relates to Medicare Advantage. I used to work for an old fellow in Illinois politics named Cecil Partee, and Cecil said: For every issue in politics, there is a good reason and a bad reason. We have the good reason on the floor for this McCain amendment and the future of Medicare.

The real reason is on the first line of Senator McCain’s motion to commit. He says: Send this back to committee and don’t touch Medicare.

I want to ask the Senator from Connecticut about Medicare Advantage, because some of the things I have read around the country about Medicare Advantage tell me this plan, run by private health insurance companies, costs more than basic Medicare. These companies promised us, when they got involved, they would show us how to run a health insurance plan. They would show us how to provide Medicare benefits and they would save us money. Some have. But by and large, if I am not mistaken, isn’t the verdict in—a 14-percent increase in cost for Medicare benefits under this Medicare Advantage?

Mr. DODD. My colleague from Illinois is absolutely correct, it is 14 percent. In some States it is 50 percent more.

Mr. DURBIN. When we talk about saving over $100 billion in the Medicare Program over the 10 years, part of it is by saying to those private health insurance companies that are overcharging Medicare recipients, the party is over. The subsidy is over. We are going to make sure that every American who qualifies for Medicare gets basic benefits, but we will not allow these private health insurance companies to get a subsidy from the Federal Government at the expense of Medicare and its recipients.

Mr. DODD. And then they are charging the other 78 percent of Medicare recipients to raise their premiums. That is the outrage of all this.

Mr. DURBIN. So the motive behind the McCain amendment is less about saving Medicare and more about saving private health insurance program called Medicare Advantage.

Mr. DODD. And talk about misbranding, calling something Medicare Advantage.
Mr. COBURN. Reserving the right to object, I will ask for 2 additional minutes for my side.

Mr. DODD. Well, I gave 2 minutes to my friends earlier.

Mr. COBURN. How about 1? The PRESIDING OFFICER, Without objection, the request is agreed to.

Mr. DODD. That is correct. None whatsoever. In fact, all they do get is higher premiums.

Mr. BAUCUS. That is right. Higher premiums.

Mr. DODD. Higher premiums. And 78 percent, almost 80 percent are paying more for a program from which they never get any benefit.

Mr. BAUCUS. The figure I saw—I guess it is $90 a year they pay extra and get no benefit from it.

Mr. DODD. The idea I had was that the McCain amendment and you do exactly what Senator DURBAN is suggesting: Preserve Medicare Advantage, and under Medicare Advantage 78 percent of our elderly pay more premiums, never get any benefit. The private carriers get to pocket the difference. That is a great vote around here. That is great health care reform.

Mr. DURBIN. I say to the Senator from Connecticut, could we characterize this as an earmark in the Medicare Advantage Program?

Mr. DODD. It is 2 cars, not even one ear. I give it two cars.

Mr. BROWN. I say to Senator Dodd, we remember 10 years ago when the insurance companies came to the government and said we can do something that later became Medicare Advantage, and we can do it less expensively. They said we can do it for 5 percent less than the cost of Medicare and the government unfortunately made the agreement with them to sign up to do that. Then what happened in the last 10 years is, the insurance lobbyists came here and lobbied the Bush administration and lobbied the Congress and got bigger payments. It is a subsidy for the insurance companies. You and Senator BAUCUS and Senator DURBAN said it is not Medicare, it is private insurance, privatized form of Medicare that serves the insurance companies very well, is that correct, but doesn’t serve the seniors.

Mr. DODD. I will sit here all day waiting for someone to identify a single benefit guaranteed under the Medicare Program that is cut in our bill. They are all talking about Medicare Advantage, not Medicare. They are no guaranteed benefits under this bill nor can those benefits be cut. Our legislation bans and prohibits any cuts in guaranteed benefits.
Mr. GRASSLEY. Madam President, on Monday the Congressional Budget Office sent a letter to the Senator from Indiana, Mr. BAYH, that provides a very comprehensive analysis of what health insurance premiums will look like as a result of the Reid bill, but, introduced by Senator Reid. Listening to that discussion, I am starting to wonder if anyone actually read the letter. I hear a lot of people saying this letter proves that premiums will go down under the Reid bill, even though that is not what the letter says. I am here to tell my colleagues what the letter really says.

The letter makes it very clear that premiums will increase on average by 10 to 13 percent for people buying coverage in the individual market. Since it seems to fly by everybody what this letter actually said about increasing premiums, I brought down a chart to show everyone in case they missed it.

The CBO says very clearly that for the individual market, premiums are going to go up 10 to 13 percent. My colleagues keep saying premiums are going to go down, conveniently forgetting, then, to mention this 10- to 13-percent increase. They prefer to talk about the 57 percent of Americans in the individual market who are getting subsidies. It is true that government is spending $500 billion in hard-earned taxpayer money to cover up the fact that this bill drives up premiums for the people who are stuck with a plan that is 10 to 13 percent more expensive and also, simultaneously, conveniently forgetting, then, to mention this 10- to 13-percent increase. So we might as well repeat it: Premiums will go up faster under this bill.

Supporters of this bill are covering this increase in cost how? By handing out subsidies. If you are one of the 14 million who doesn’t happen to get a subsidy, you are out of luck. You are stuck with a plan that is 10 to 13 percent more expensive and also, simultaneously, with it, an unprecedented new Federal law that mandates that you purchase insurance. If you don’t purchase insurance, you are going to pay a penalty to the IRS every time you file your income tax. Some may say this is just the individual market. It only accounts for a small portion of the total market. If you are comfortable with 14 million people paying more under this bill than they would under current law, let’s look at the employer-based market.

The Congressional Budget Office analysis says this bill maintains the status quo in the small group and large group insurance market. Is that something to be celebrating? Are expectations so low at this point that my friends on the other side of the aisle are celebrating that this bill will increase premiums for some and maintain the status quo for everyone else? I am being generous in using the phrase “status quo” because this bill actually makes things worse for millions of people.

The bill is so bad that my friends on the other side of the aisle are trying to convince the American people that this is just more of the same, when that doesn’t happen to be the case.

Whatever happened to bending the growth curve? If that is too Washingtonese for people, the goal around here of a bill at one time was to make sure the inflation in insurance didn’t continue to go up so much that it would continue to go up faster under this bill than they would under current law, this bill will either raise premiums 1 percent or decrease them a whopping 2 percent. It doesn’t sound like this bill is providing any real relief or, for sure, not providing $2,500 savings for every American, as President Obama repeatedly pledged during the campaign. Larger businesses would pay premiums 2 percent more and 2 percent less for health insurance. That means, of course, that compared to what businesses would have paid under current law, this bill will either raise premiums 1 percent or decrease them a whopping 2 percent. It doesn’t sound like this bill is providing any real relief or, for sure, not providing $2,500 savings for every American, as President Obama repeatedly pledged during the campaign.

In fact, the Congressional Budget Office has confirmed that between now and 2016, 17 percent of our economy, or $500 billion, will be spent on health care, and not cutting costs. Don’t take my word for it. Read the letter. Read the letter from the Congressional Budget Office. I have copies I will pass out if anybody wants them. I have this chart that demonstrates that point.

I also wish to take a few minutes at this time to correct some inaccurate comments made earlier by some of my colleagues. When we are talking about 17 percent of the economy and something that touches the lives of every single American, I want to make sure we have an honest and accurate debate.

This morning I heard at least three Members on the other side of the aisle say that Medicare Advantage is not part of Medicare. This is totally false. But don’t take my word for it. I would like to have Members turn to page 50 of the handbook, “Medicare and You.” Presumably it has the date of 2010 on it. It is sent out every year. In fact, I think I have this in my household. If anybody wants to save paper and not waste taxpayer money, they can get on the Internet and tell them only to send one to their house next year. I have done that.

This book says, for those who say Medicare Advantage is not part of Medicare:

A Medicare Advantage plan is another Medicare program. It is like more of the same. Once again, Members want lower costs. That is their main concern. But this bill fails to address that concern because it raises taxes, higher premiums, increased deficit, less Medicare. They are celebrating that they spent $2.5 trillion to raise premiums for 14 million people, not bending the growth curve of inflation, health care, and not cutting costs. Don’t take my word for it. Read the letter. Read the letter from the Congressional Budget Office. I have copies I will pass out if anybody wants them. I have this chart that demonstrates that point.

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these benefits after health reform is passed.

The Senator from Connecticut challenged any Member to come down to the Senate floor and point out where this bill will cut benefits. He even read a section from page 1,004 of the 2,074-page bill. My question is about how the Medicare Commission cannot cut benefits or ration care. I have read page 1,004. What Senator Dodd failed to mention is that this section only refers to Parts A and B of Medicare. It fails to protect any protection to Medicare Part D, the prescription drug benefit, or the Medicare Advantage Program that covers 11 million seniors.

Are we now going to start hearing that Medicare Part D is not part of Medicare either? In fact, on page 1,005, it specifically says the Medicare Commission can “[i]nclude recommendations to reduce Medicare payments under parts C and D.”

I have asked CBO, and they have confirmed that austerity could result in higher premiums and less benefits to seniors. In fact, this is what Congressional Budget Office Director Elmen
dorf said, and we have that on a chart for you to see the quote I am going to read: “The reduction in subsidies to [Part D] would raise the cost to beneficiaries.”

Lastly, I wish to raise an issue about access to care. I keep hearing my friends on the other side of the aisle talk about how these cuts will not af
dict seniors. They say they are just overpayments to providers. Well, in my opinion, if you cannot find a doctor or if you cannot find a home health pro
d or a hospice provider to deliver care, then that tends to be a very big problem. I would even consider that a cut in benefits or hurting access to care.

But, once again, do not take my word for it. In talking about similar cuts to Medicare Part D, the Office of the Actuary at the Centers for Medi
care & Medicaid Services said providers that rely on Medicare might end their participation, “‘[p]ossibly jeopardizing access to care for beneficiaries.’”

So let’s be accurate and let’s be hon
est. Medicare Advantage is part of Medicare, and this bill cuts benefits seniors have come to rely upon. The Medicare Commission absolutely has authority to cut benefits and to raise premiums, and this bill will jeopardize that access to care.

Those are all facts. They are not my facts but facts taken directly from the language of this 2,074-page bill and from reports of the Congressional Budget Office and the Office of the Ac
tuary at the Centers for Medicare & Medicaid Services.

I yield the floor.

The PRESIDING OFFICER. The Sen
tor from Illinois.

Mr. DURBIN. Madam President, it seemed following the Senator from Iowa every day. I, first, wish to ac
tnowledge my friendship and respect for him. But the Medicare Advantage Program, which the Republican side is trying to protect, is a program which is private health insurance.

The largest political opponent to health care reform in America is the private health insurance industry. We estimate that they can cut Medicare $170 billion over the next 10 years—no small amount. We believe that money is better spent on extending benefits to Medicare beneficiaries, not in pro
ducing additional profits to already profitable private health insurance companies.

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tuary at the Centers for Medicare & Medicaid Services.

I yield the floor.
lost their job; denied coverage because of a cap in the amount of money the policy would pay; rescinded, where they walk away from an insurance policy because of some objection they have, legal objection; or how about one of your kids who turned 24, no longer covered by your family health plan, now out on their own, maybe fresh from college, and has no job and no health insurance.

This bill addresses those issues. This bill eliminates the concern people will have over a preexisting condition. It takes away the power of the health insurance companies to say no. It finally creates a situation, which we have waited for for a long time. America is the only civilized, industrialized country in the world where a person can die for lack of health insurance. It does not happen anywhere else—only in America. Madam President, 45,000 people a year die for lack of health insurance.

Who are these people? Let me give you an example, one person whom I met. Her name is Judy, and she works in a motel in southern Illinois. She is 60 years old, a delightful, happy woman. She is the one who takes the dishes at the end of this little breakfast they offer at the motel. She could not be happier and nicer. She is 60 years old, with diabetes. She never had health insurance in her life—never. She goes to work every day, works 30 hours a week, makes about $12,000 a year. She does not have health insurance, but she does have diabetes. She said to me: If I had health insurance, I would go to the doctor. I have had some lumps that have concerned me for a little while here, but I can’t afford it, Senator.

That is an example of a person who does not have the benefit of health insurance. This bill we are talking about—this bill we are going to produce through the Internet; it is already there; it has been there for 10 days already; it will continue to be there—this bill makes sure that 94 percent of the people in America have health insurance coverage. That is an all-time high for the United States of America. I might also say, despite the criticisms—and they are entitled to be critical on the Republican side of the aisle—they have yet to answer the most pointed question of all they have ever asked me: What is your plan? Where is your plan? Where is the Republican health care reform bill? They cannot answer that question because it does not exist. They have had a year to explore their ideas and develop them, but they have failed. They cannot produce a bill. They are for the current system, as it exists, that is unsustainable, unaffordable, leaving too many Americans vulnerable to health insurance companies that say no and too many Americans without health insurance.

I wish to address one particular issue that seems to come up all the time, and it is the issue of medical malpractice. I know my Republican colleagues are going to bring up that issue. Senator McCAIN has, many others have as well. President Obama recently recognized this as an issue of concern. Our bill will as well. We are going to explore, encourage, and fund the States to try to reduce medical malpractice premiums and to reduce, even more importantly, the incidence of medical errors.

Medical malpractice reform proposal. Senator BAUCUS, who is the author of this bill, does not have a medical malpractice law, not in general terms. It does for specific programs such as Indian health care, for example, or federally qualified clinics. But when it comes to the general practice of medicine, that is governed by State laws, and the States decide when you can sue, what you can sue for, and the procedures you have to follow.

In almost every State there has been a system that has developed over the years to handle the cases that regularly change and update their laws. The States try to strike a balance to protect patients, preserve their hospitals and doctors and other medical providers, ensure that those who are injured can get compensation, and manage the cost of their system.

At least twenty-eight States, as of last year, have decided to impose caps on noneconomic damages in medical malpractice cases. And before I came to Congress, I used to be a practicing lawyer in Springfield, IL, and I handled medical malpractice cases. So I do not profess to be an expert, nor even have current knowledge of medical malpractice, but I did in a previous life have some experience. I defended doctors, when they were sued, for a number of years on behalf of insurance companies, and I represented plaintiffs who were victims of medical negligence, both on the sides of the table. I have been in the courtroom. I have gone through the process.

Here is what it comes down to. If you are a victim of medical malpractice, medical negligence, the jury can give you an award, which usually includes a number of possibilities: pay your medical bills, pay for any lost wages, pay for any additional expenses that may be associated with the court case, and the jury can give you a figurement—is an area where many States have said: We want to limit the amount you can recover for pain and suffering, what they call noneconomic losses. It is not medical bills. It is not lost wages. So my State, for example, has a limitation of $500,000 on noneconomic damages in a medical malpractice case, recently enacted by our general assembly. In the State of Texas, it is $250,000. Those are so-called caps, limitations on the amount of money a jury can award for pain and suffering, when they find, in fact, you were a victim of medical negligence.

Some States have decided to establish caps on pain and suffering, how much you can recover; obviously, that is not. Minnesota is an interesting example. Minnesota does not have caps on damages. Yet it has some of the lowest medical malpractice premiums in America. Twenty-five States, including Minnesota, have a certificate of merit system which means before you can file a lawsuit you need a medical professional to sign an affidavit that you have a legitimate claim before you even get into the court. That is in Minnesota, in Illinois, and a number of other States to stop so-called frivolous lawsuits.

Some States such as Vermont have low malpractice premiums and don’t have any malpractice reforms. It is hard to track causation and effect here between tort reform, malpractice changes, and the actual premiums charged physicians.

There are ways Congress can help States build on what already works for each State. Senator BAUCUS, who is here on the floor and who is chairman of the Senate Finance Committee, has worked with Senator ENZI to create incentives for State programs to look for innovative ways to reduce malpractice premiums and the medical malpractice premiums for doctors and hospitals. Well, a number of States have done that. At least twenty-eight States have done that, and we have been able to step back and take a look: How did it work? If you put a cap, a limitation, on recovery for pain and suffering, noneconomic loss, does that mean there will be lower malpractice premiums for doctors? In some cases, yes; in some cases, no.

Minnesota is an interesting example. Minnesota does not have caps on damages. Yet it has some of the lowest medical malpractice premiums in America. Twenty-five States, including Minnesota, use a certificate of merit system which means before you can file a lawsuit you need a medical professional to sign an affidavit that you have a legitimate claim before you even get into the court. That is in Minnesota, in Illinois, and a number of other States to stop so-called frivolous lawsuits.

One of the major considerations when it comes to medical malpractice reform is making sure we focus on real facts. One myth we hear over and over again is about frivolous lawsuits flooding the courts. I have heard many colleagues come to the floor and call it “jackpot justice,” frivolous lawsuits, fly-by-night lawyers filing meritless malpractice lawsuits. I am sure there is anecdotal evidence for each and every statement, but when you look at the record, you find that malpractice claims and lawsuit payouts are actually decreasing in America.

In 2008, according to the Kaiser Family Foundation, there were 11,025 paid medical malpractice claims against physicians nationwide. One year in America, the total number of medical malpractice claims paid, according to the Kaiser Family Foundation, was 11,025. There are 990,000 doctors in America, so roughly 1 percent of doctors is being charged with malpractice
and paying each year. This is a decrease from 2007 where the number was 11,478. So the number of medical malpractice claims has gone down. The number of paid claims for every 1,000 physicians has decreased from 25.2 in 1991 to 11.1 in 2003. That is a little over 1 percent of doctors actually paying medical malpractice claims.

Not only is the number of claims decreasing, but the amount they are paying to victims is decreasing as well. The American Medical Association of Medical Liability Commissioners, a group that is biased one way or the other when it comes to plaintiffs or defendants—said in 2003, malpractice claim payouts peaked at $8.36 billion. In 2008 that number had been cut in half. In 5 years it went down from $8.4 billion to $4 billion. So rather than a flood of frivolous lawsuits, fewer lawsuits are being filed and dramatically less money is being paid out.

Incidentally, the New York Times in a summary of research in September of this year found that only 2 to 3 percent of medical negligence incidents actually lead to malpractice claims. So it is not credible to argue that we have this flood of malpractice cases—they are going down. A flood of payouts for malpractice in America. It has been cut in half in 5 years.

A third key consideration in this debate is cost. One of the main goals of pursuing health care reform is to try to reduce costs to the system and we want to try to do that in a way that won’t compromise the quality of care. There has been a lot of talk about the Congressional Budget Office report that was ordered up by Senator HATCH on October 9. The Congressional Budget Office for years said they could not put a price tag on medical malpractice reform in terms of savings to the system, but on October 9 they reported to Senator HATCH that they could. Senator HATCH, or this Judith balls, or this James balls, or this CBO examiners. So if you accept their projection on the savings for medical malpractice reform asked for by Senator HATCH, you cannot escape the fact that they say yes, you will save money, but more Americans will be killed because there will be more malpractice.

Let’s look at the savings that can be achieved through reduced malpractice insurance premiums. The CBO said a $250,000 Federal damage cap would reduce overall malpractice premiums by about 10 percent and would reduce overall health care spending by .2 percent. Do we need a federally mandated cap to achieve that? Malpractice insurance premiums are already going down. The CBO analysis that Senator HATCH received went on to say:

Because medical malpractice laws exist to allow patients to sue for damages that result from negligent health care, imposing limits on that right might be expected to have a negative impact on health outcomes.

They cited one study which found that a 10-percent reduction in costs related to medical malpractice liability would increase the Nation’s overall death rate by .2 percent. By calculation that means that if the Hatch proposal were applied nationwide, according to the CBO—and this is a cited study—4,833 more Americans would be killed each year by medical malpractice—or $250,000 for pain and suffering—I see that as the Senator from Texas on the floor .

I wish to also say a word about the medical malpractice insurers. Remember, insurance companies and organized baseball are the only two businesses in America exempt from the antitrust laws. What it means is that insurance companies can literally legally sit down and collude and then it comes to the prices they charge, and they do. They have official organizations—one used to be known as the Insurance Services Offices—that would sit down to make sure insurance companies knew what the other insurance company was charging, and they could literally work out the premiums, how much they charge.

The same thing was true in market allegations. Insurance companies, unlike any other business in America, can pick and choose where they will do business: Company X, you take St. Louis; company Y, you take Chicago; company Z, you get Columbus, OH. They can do it legally.

So the obvious question is: If this is not on the square in terms of real competition from health insurance companies, are these companies, in fact, paying the kind of money they should?

Let me see if I can find a chart here. My staff was kind enough to bring these out. Well, I can’t. They are great charts, but I can’t find the one I am looking for at this moment.

According to the information of the National Association of Insurance Commissioners, in 2008, medical malpractice insurers charged $11.4 billion...
in premiums, but only paid out $1.1 billion in losses. In other words, they took in $7 billion more than they paid out in losses. That is a loss ratio of 36 percent, which means they are basically collecting $3 for every $1 they pay out—how does that compare to the rest of the insurance industry? Well, it turns out that private automobile liability insurance had a loss ratio of 66 percent, a payout of $2 out of every $3; homeowners, 72 percent; and workers compensation, 85 percent. These medical malpractice insurance companies are holding back premiums and not paying them out. It reached a point in my State where our insurance commissioner ordered that they declare a dividend and pay back some of the premiums they had collected from doctors and hospitals when it came to malpractice insurance.

But rather than get lost in statistics, as important as they are, I think it is important that we also talk about the real people that are involved in medical malpractice. I hear these terms such as “frivolous lawsuits” and “jumpjack justice” and people taking advantage of the system, but let’s not forget the real life stories that lie behind the practice. Let me show my colleagues a picture here of a couple. This is Molly Akers of New Lenox, IL, a lovely young lady, with her husband. Molly Akers had a swelling in her breast and went to her doctor who performed a biopsy that showed she had breast cancer. Molly had several mammograms which found no evidence of a tumor, but the doctors decided that despite the mammograms, she must have a rare form of breast cancer. They recommended a mastectomy, removing Molly Akers’ right breast. After the operation, the doctor called her into the office and said that on further review, she never actually had breast cancer. The radiologist had made a mistake. He reviewed her slides and mistakenly switched Molly’s slides with someone else. Molly was permanently disfigured by an unnecessary surgery. She said afterwards:

I never thought something like this could happen to me, but I know now that medical malpractice can ruin your life.

By the way, that other woman whose slides were switched with Molly’s was told she was cancer free. What a horrific medical error that turned out to be.

This next picture is of Glenn Steinberg of Chicago. He went into surgery for the removal of a tumor in his abdomen. Ten days after the surgery, while still in the hospital, Glenn was having severe gastrointestinal problems. The doctor went to the bathroom, just before the original surgery took place, and they found a 4-inch metal retractor from the surgery lodged against his intestine. A second surgery was performed to remove the metal piece, during which Glenn’s lungs aspirated, and he died later that night.

Glenn’s wife, Mary Steinberg, lost her husband. She said:

Not a day goes by that I don’t miss Glenn’s companionship and the joy he brought to our household. Because of gross negligence, he was not here to support me when my son went off to serve in Iraq.

In this photo is a group of kids, including Martin Hartnett of Chicago. When Martin’s mom Donna arrived at the hospital to deliver, her labor wasn’t progressing. Her doctor broke her water and found out that it was abnormal.

Rather than considering a C-section, Donna’s doctor started to administer a drug to induce contractions. Six hours later, she still hadn’t delivered, but her son’s fetal monitoring system began indicating that he was in severe respiratory distress. The doctor finally decided it was time to perform an emergency C-section, but it was another hour before Donna was taken into the operating room.

During that time, the doctor failed to administer oxygen or take immediate steps to help Martin breathe. After he was born, Martin was in the intensive care unit for 3 weeks. Later, Donna learned that Martin had substantial brain damage and cerebral palsy—a direct result of failure to respond to indications of serious oxygen deprivation and delivery in a timely manner.

Donna’s doctor told her not to have any more children because there was a serious problem with her DNA, which could result in similar disabilities in any of her future kids. Since then, Donna has given birth to three perfectly healthy sons.

Donna sued the doctor responsible for Martin’s delivery and received a settlement. She is thankful she has money from the settlement to help cover the costs associated with Martin’s care that aren’t covered by health insurance, such as the wheelchair-accessible van that she bought for $50,000 and the $100,000 she spent making changes to her home so her son can get around the house in a wheelchair.

What would Donna have done without the money from that settlement? It is a scary thought because Martin is going to require a lifetime of care. When we put caps on recoveries and say there is an absolute limit to how much someone who has created a problem has to pay out, we have to think about it in terms of real-life stories, such as Martin. Martin will live for a long time, and he is going to need help. Somebody needs to be responsible for that. The person who caused this should be responsible for it. That is pretty basic justice in America.

When you establish an artificial cap on noneconomic losses for pain and suffering, then you are saying there is a limit to how much can be paid. I recall the case of a woman in Chicago who went into a prominent hospital—one that I have a great deal of respect for—to face a very serious medical condition. She never had to face a very simple mole removal. They gave her a general anesthesia. In the course of that anesthesia, they gave her oxy-

The oxygen tank—in the administration of it—caught fire, literally burning off her face. She went through repeated reconstructive surgeries. I have met her. There was scarring and, as you can imagine, a lot of pain. Was there any money left for what she went through? Her life will never be the same. That is the kind of disfigurement covered by noneconomic losses that would be limited by medical malpractice caps.

There are better ways to do this. We can, in fact, reduce the cost of medical malpractice insurance. We can, in fact, reduce medical errors. We should not do it at the expense of innocent victims—people who went in, with all the trust in the world, to doctors and hospitals and had unfortunate and tragic results.

Every time I get up to speak on this subject I always make a point of saying—and I will today—how much I respect the medical profession in America. There isn’t one of us in this Chamber, or anyone watching this, who can’t point to men and women in the practice of medicine who are true heroes in their everyday lives. We are fortunate greatly to become doctors, and who work night and day to get the best results for their patients. They richly deserve not only our praise but our respect.

But there are those who make mistakes—serious mistakes. There are innocent victims who end up with their lives changed or lost because of it. We cannot forget them in the course of this debate. This is not just dollars and cents. It is about justice in this country. I urge my colleagues, when the issue of medical malpractice comes before us, to remember the doctors but not to forget the victims and their families.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. CORNYN. Madam President, with their collective effort in Illinois is still on the Senate floor, I always enjoy listening to him. He is one of the most effective advocates, and he is an outstanding lawyer. He and I frequently disagree, but I always enjoy listening to his arguments. That isn’t what I came to talk about, but I am glad I happened to be here when he talked about the successful effort we have had in Texas, through medical liability reform, laws, to make medical liability insurance more affordable for physicians and, as a consequence, increase the number of doctors who have moved to our State, including rural areas, which has increased the public’s access to good, quality health care. When 360 doctors in the state, where they didn’t even have an OB-GYN, or obstetrician—a doctor who delivers babies—after medical liability reform, that has changed dramatically, along with a number of other high-risk specialties that have moved to these counties where they were previously afraid to go for risk of litigation and what that might mean to their future and career.
This is an important topic. We will talk about it more. I appreciate the Senator raising the issue. We have a different view about it. If we can save $54 billion and still allow each of these people who were harmed by medical negligence to recover their lost wages, their medical bills, and they would be able to receive large amounts of money for pain and suffering under the Texas law, I don't think we would be able to recover their lost wages, their medical bills, and they would be able to receive large amounts of money for pain and suffering under the Texas law.

There needs to be some reasonable limitations that will help, in the end, make health care more accessible, which is what we are talking about. I want to focus briefly on the cuts to Medicare, huge payouts of legislation we are considering. Of course, we are told by the CBO that as a result of Medicare cuts and the huge number of tax increases this bill is “paid for.”

But if you take it on faith that we are going to raise taxes by $1/2 trillion and cut Medicare by $1/4 trillion, they say this is what the neutral bill—outstanding the fact that it spends $2.5 trillion over 10 years—basically, what we are saying to America's seniors, those already vested in the Medicare Program, is that we are going to take $464 billion that would go into the Medicare Program and we are going to use it to create a new government entitlement program.

Our record of fiscal responsibility, when it comes to entitlement programs, is one that, frankly, promises coverage to one in five Medicare beneficiaries, and Medicare beneficiaries are way over a billion dollars in unfunded liabilities. Most of them are riddled with fraud, waste, and abuse.

The question I have, and I think many have, is why in the world would you take money out of the Medicare Program that is scheduled to go insolvent in 2017, that has tens of millions of dollars in unfunded liabilities, why would you take $8 trillion out of Medicare to create yet another entitlement program that, no doubt, will have many of the problems we see now under our current entitlement programs? It just doesn't make sense, if you are guided by the facts.

Of course, our colleagues on the floor have said: We can cut $465 billion out of Medicare and, you know what, Medicare beneficiaries would not feel a thing.

Well, I don't think that is possible when you cut $135 billion in hospital payments, when you cut $120 billion out of Medicare Advantage on which 11 million seniors depend, on which they depend for their health care, or when you cut $15 billion from payments to nursing homes, another $40 billion in home health care. I think one of the most effective ways of delivering low-cost health care is in people’s homes. You would also cut Medicare by $8 billion from hospice, which is where people go during their final days in their terminal illness.

Some of my colleagues claim these cuts were offered to the patient, but many people, including our colleagues, and I, as a matter of fact, to quote President Obama’s own Medicare actuary, he said providers might end their participation in the program. In other words, as in Medicare now, in my State, 50 percent of doctors will see a new Medicare patient because reimbursement rates are so low. Yet we are going to take money from Medicare to create a new entitlement program that would mean, in my mind that providers—in the words of the Medicare actuary—might be hedging their bets. I think he is hedging his bets. He also said many will end their participation in the program and thus jeopardize access to care for beneficiaries.

We have heard some of the debate earlier about when our side of the aisle made proposals to fix some of the problems with the Medicare Program—not to create a new entitlement program—by taking this amount of money, $464 billion, from it. When we tried to fix it earlier, some colleagues, including the majority leader, called those cuts immoral and cruel. To quote President Obama, he was one of those who criticized Senator McCain for some of the proposals he made to try to fix the broken Medicare Program.

As we have heard from a Texas Hospital Association, the Medicare cuts to hospitals simply will not work because—and this is another sort of accounting trick that in Washington, DC, and in Congress people think we can get away with and fool the American people that is actually happening. People are a lot smarter than I am sure not enough to compensate them for what they have been suffering—I am sure not enough to compensate them for what they have been suffering. They have to take this path, and one that, frankly, promises coverage but ultimately denies access to care because of unrealistically low payments to providers. We are going to make that worse if this bill passes, not better.

Well, this bill also includes something else that I think the public needs to be very aware of. It uses not only budget gimmicks that our friends on the other side have said this bill can't extend the life of the Medicare trust fund for a few years, the problem is it doesn’t solve the fundamental imminent bankruptcy of Medicare. That is left with the options the bill purports by the distinguished majority leader creates a new, unaccountable, unelectable board of bureaucrats to make further cuts to Medicare Programs.

After the Reid bill pillages Medicare for $1/2 trillion, as I said, to pay for a new entitlement, it creates a board of unelected, unaccountable bureaucrats, the so-called Medicare advisory board, which sounds pretty innocuous, but they have been given tremendous power—to meet budget targets—another $23 billion in the first years alone.

If Congress doesn’t substitute those cuts with other cuts to providers or benefits, the board’s Medicare cuts would go into effect automatically. The Government Accountability Office, the Medicare Trustees, physicians, hospitals, and everyone else who depends on Medicare would have no say in what happens to personal medical decisions because they would just be cut and shut down by this elected, appointed board.

The government-charted boards of experts we have in existence today are not always right. We may remember the Medicare Payment Advisory Commission, so-called MedPAC, which was created by Congress in 1997, has recommended more than $200 billion in cost cuts in the last year alone that Congress has not seen fit to order. In other words, this MedPAC board makes recommendations, and Congress is then left with the option to act to make those cuts. Congress has said no to the tune of $200 billion in the last year alone.

Then there is another relatively notorious board of experts—unaccountable, faceless, nameless bureaucrats—that we have learned a little bit about in the last few days: the U.S. Preventive Services Task Force. They are supposed to recommend preventive services but just recently said that women under the age of 50 do not need a mammogram to screen for breast cancer. Respected organizations, such as the American Cancer Society and the Komen Advocacy Alliance, disagree based on their own rigorous review of the latest medical evidence.

I have talked about the broken Medicare Program and, frankly, I think a lot of people would rather see us fix Medicare and Medicaid before we create yet another huge entitlement program that is riddled with fraud, that is on a discursive path, and one that, frankly, promises coverage but ultimately denies access to care because of unrealistically low payments to providers. We are going to make that worse if this bill passes, not better.
that can make cuts, based on expert advice, which will ultimately limit access to diagnostic tests, including tests such as mammograms, which became very controversial. The Secretary of Health and Human Services came out immediately and said: We will never allow that to happen. And I agree with them.

Not even the Secretary of Health and Human Services, under this provision, could reverse the decision of this unelected, unaccounted board which may well—I would say probably will in some cases—limit a person's access to diagnostic tests and procedures that could save their life even though their personal physician in consultation with that patient, may say: This is what you need. When you give that power to the government, not only to render expert advice but then to decide whether to pay or not to pay for a procedure, then the government—namely, some bureaucrat in Washington, DC—is going to make the decisions based on a cost-benefit analysis.

OK, on a cost analysis, we can afford, according to the decision of the U.S. Preventive Services Task Force, to lose women to breast cancer—women between the age of 40 and 49—because we don’t think they need a mammogram. And on a cost-benefit analysis, they may say: Tough luck. But that is not where we should go with this legislation.

Many health care providers are concerned about the Medicare Payment Advisory Commission. According to a letter from 20 medical specialty groups, they said:

We are writing today to reiterate our serious concerns with several provisions that were included in the health care reform bill . . . and to let you know that if these concerns are not adequately addressed when the health care reform package is brought to the Senate floor, we will have no other choice but to oppose the bill.

Included in those concerns was the “establishment of an Independent Medicare Commission whose recommendations could become law without congressional action” . . .

According to a letter from the American Medical Association today:

AMA policy specifically opposes any provision that would empower an independent commission to mandate payment cuts for physicians. . . . Further, the provision does not apply equally to all health care stakeholders, and for the first four years significant portions of the Medicare program would be cut out of our savings . . .

This is an example of another trade association that basically decided to cut a deal with the administration behind closed doors, and they have been prevented from some of these cuts under this Medicare Commission while physicians have not been prevented from similar treatment, and they do not think it is fair. They think it is unfair, and I agree with them.

This letter goes on to say:

In addition, Medicare spending targets must be set with increases in volume that may be a result of policy changes, innovations that improve care, greater longevity, and unanticipated spending for such things as influenza pandemics. These are critical issues with the potential for significant adverse consequences for the program, which must be properly addressed through a transparent process that allows for notice and comment.

Sounds to me as if the American Medical Association thinks this is a lousy idea, and I agree with them.

Artificial budget sequestration means that the Medicare advisory board would have to meet leave virtually no room for medical innovation. It is unbelievable what medical science in America and across the world has done to increase people’s ability to live longer, as a result of heart disease, for example. People who would have died in the seventies are today living healthy because they are taking prescription medications to keep their cholesterol in check, and they have access to innovative surgical procedures, such as stents and other things that can not only improve their quality of life but their longevity as well.

If we have the Medicare advisory board saying: We are not going to pay for some of it to crush medical innovation and have a direct impact on quality of life and longevity. What if we find a cure for Alzheimer’s in 2020, but because this board says: It is too expensive, we are not going to pay for it, you are out of luck. What if there are things we cannot anticipate today, which we know there will be because who ever heard of the H1N1 virus or swine flu just a year ago?

Some of my colleagues have said an “independent board,” such as the Medicare advisory board, would insulate health care payment decisions from politics. But the very charter of the Medicare advisory board was the result of a deal cut behind closed doors with the White House, a political deal, and it has a lot of reasons why, as we can tell, I don’t think it is going to work well.

According to Congress Daily:

Hospitals would be exempt from the (board’s) ax, according to the committee staff, because they already negotiated a cost-cutting agreement with [the chairman of the Finance Committee] and the White House. “It’s something that we worked out with the committee, which considered our sacrifices,” said Richard Coorsh, spokesman for the Federation of American Hospitals. A committee aide said spokesmen for the American Hospital Association reiterated that hospitals received a pass—

They were protected from 4 years of cuts—based on the $155 billion cost-cutting deal already in place.

Is that the kind of politics we want to encourage behind closed doors—deals cut to protect one sector of the health care industry and sacrifice another while denying people access to health care? That is the kind of politics I would think we would want to avoid.

The truth is, the Reid bill gives more control over personal health decisions to Washington, DC, where politics will always play a role in determining winners and losers when the government is in control because people are going to come to see their Members of Congress and say: Will you help us? We are your constituents. And Members of Congress are always going to try to be responsive, if they can, within the bounds of ethics to their constituents.

This needs to be not a process that is dictated by politics but on the merits and on the basis of the sacred doctor-patient relationship. If we really want to insulate health care from politics, we need to give more control to patients—to patients, to families, to mothers and fathers, sons and daughters—to make health care decisions in consultation with their physician, not nameless, faceless, unaccountable bureaucrats.

I filed an amendment to completely strike the Medicare advisory board from the Reid bill and urge my colleagues to support it at the appropriate time. The Medicare advisory board empowers bureaucrats to make personal medical decisions instead of patients, whose power to determine their own future, in consultation with their doctor, we ought to be preserved.

The Medicare advisory board is an attempt to justify the $½ trillion pillaging of Medicare from America’s seniors to create a new entitlement program that should stand for nearly $38 trillion in unfunded liabilities, not steal from a program that is already scheduled to go insolvent in 2017.

At a time of insolvent entitlement programs, record budget deficits, and unsustainable national debt, this country simply cannot afford a $2.5 trillion spending binge on an ill-conceived Washington health care takeover.

I yield the floor.

Mr. GREGG addressed the Chair.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Madam President, it is the tradition in this body that a person seeking recognition gets recognized, is it not?

The PRESIDING OFFICER. It is, and I say the Senator from California was here earlier.

Mrs. FEINSTEIN. If I might, Madam President, my understanding was we alternate, go from side to side. I have been sitting here waiting.

Mr. GREGG. Madam President, I believe I have the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Madam President, I ask unanimous consent that at the conclusion of remarks of the Senator from California, I be recognized.

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

The Senator from California.

AMENDMENT NO. 2791

Mrs. FEINSTEIN. Madam President, I admire the Senator’s gentility. I think we should very much raise concerns about this.

I raise to say a few words on behalf of the Mikulski amendment, but before I do, I wish to make a generic statement.
Those of us who are women have essentially had to fight for virtually everything we have received. When this Nation was founded, women could not inherit property and women could not receive a higher education. In fact, for over two centuries of our Nation’s life, women could not vote. It was not until 1920, after perseverance and demonstrating, that women achieved the right to vote. Women could not serve in battle in the military, and today we now have the first female general. So it has all been a fight.

Senator MIKULSKI and Senator BOXER in the House in the 1980s carried this fight. Those of us in the 1990s who came here added to it. You, Madam President, have added to it in your remarks earlier. The battle is over whether women have adequate prevention services provided by this bill. I thank Senator MIKULSKI and Senator BOXER for their leadership and for their perseverance and their willingness to discuss the importance of preventive care and health care for women. Also, I thank Senator SHAHEEN, Senator MURRAY, and Senator GILLIBRAND, joined by Senators HARKIN, CARDIN, DODD, and others, for coming to the floor and helping this battle.

The fact is, women have different health needs than men, and these needs often generate additional costs. Women of childbearing age spend 68 percent more in out-of-pocket health care costs than men. Most women don’t know that, but it is actually true. So we believe all women—all women—should have access to the same affordable preventive health care services as women who serve in Congress, no question.

The amendment offered by Senator MIKULSKI—and she is a champion for us—will ensure that, in fact, the case. It will require insurance plans to cover at no cost basic preventive services and screenings for women. This may include Pap smear, family planning, screenings to detect postpartum depression, and other annual women’s health screenings. In other words, the amendment increases access to the basic services that are a part of every woman’s health care needs at some point in her life.

Let me address one point because there is a side-by-side amendment submitted by the Senator from Alaska. Nothing in our bill would address abortion coverage. The provision has never been defined as a preventive service. The amendment could expand access to family planning services—the type of care women need to avoid abortions in the first place.

As I mentioned, the Senator from Alaska has offered an alternative version of this proposal. But regardless of the merits or problems with her proposal, it remains a kind of budget bust-er. According to the CBO, the amendment would cost $30.6 billion over 10 years. Cost-lier than the underlying bill, as written, reduces the budget deficit by $130 billion in the first 10 years and as much as $650 billion in the second 10 years. This is a very important thing, in my view, and we need to maintain these savings. The Mikulski amendment could do that. It costs $940 million over the first 10 years as opposed to the $24 billion to $30 billion in the Murkowski amendment.

The Mikulski amendment is, I believe, the best way to expand access to preventive care for women, while keeping this bill fiscally responsible. We often like to think of the United States as a world leader in health care, with the best and the most efficient system. But the facts actually do not bear this out. The United States spends more per capita on health care than other industrialized nations but in fact has worse results. According to the Commonwealth Fund, the United States ranks No. 15 in avoidable mortality. That means avoidable death. This analysis measures how many people in each country survive a potentially fatal yet treatable medical condition. The United States lags behind France, Japan, Spain, Sweden, Italy, Australia, Canada, and several other nations.

According to the World Health Organization, the United States ranks No. 24 in the world in healthy life expectancy. This term measures how many years people can expect to live at full health—robust health. The United States again trails Japan, Australia, France, Sweden, and many other countries.

These statistics show we are not spending our health care resources wisely. The system is failing to identify and treat people with conditions early on that can be controlled. Part of the answer, without question, is expanding coverage. Too many Americans cannot afford basic health care because they lack health insurance. But another piece of the puzzle is ensuring this coverage provides affordable access to preventive care—the ability to be screened early—and that is what the Mikulski amendment will accomplish.

Women need preventive care—screenings and tests—so that potentially serious or fatal illnesses can be found early and treated effectively. We all know individuals who have benefited from care—mammograms that suddenly identify an early cancer before it has spread or before it has metastasized; a Pap smear that finds precancerous cells that can be removed before they progress to cancer and cause serious health problems; cholesterol testing or a blood pressure reading that suggests a person might have cardiovascular disease which can be controlled with medication or lifestyle changes. This is how health care should work—a problem identified and resolved early. The Mikulski amendment will give women more access to this type of preventive care.

Statistics about life expectancy and avoidable mortality can make it easy to forget that we are talking about real patients and real people who die too young because they lack access to health care. Physicians for Reproductive Choice and Health shared the following story, which comes from Dr. William Leininger in California, and here is what he says:

In my last year of residency, I cared for a number of two who had been treated for cervical cancer when she was 23. At that time, she was covered by her husband’s insurance, but it was an abusive relationship and she lost her health insurance when they divorced. For the next 5 years, she had no health insurance and never received follow-up care, which would have revealed that her cancer had returned. She eventually remarried and regained health insurance, but by the time she came back to see me, her cancer had spread. She had two children from her previous marriage, and her driving motivation during her last rounds of palliative care was to survive long enough to ensure that her abusive ex-husband wouldn’t gain custody of her children after her death. She succeeded. She was 28 years old when she died.

Cases like these explain why the United States trails behind much of the industrialized world in life expectancy. For this reason, we must end the loss of her health coverage, which meant she could not afford follow-up care to address her cancer—a type of cancer that is often curable if found early. And that is where prevention comes in. So this tragic story illustrates the need to improve our system so women can still afford health insurance after they divorce or lose their jobs. And it shows why health reform must adequately cover all the preventive services women need to stay healthy.

The Mikulski amendment is a fight—I am surprised, but it is a fight—but it will help expand access to preventive care while keeping the bill fiscally responsible. To me, it is a no-brainer. If you can prevent illness, you should. In and of itself it will end up being a cost savings. So I have a very difficult time understanding why the other side of the aisle won’t accept that this is more fiscally responsible by far than their measure, will do the job, and will give women preventive care and begin to change to that statistic which shows that, among other nations, we do so badly.

I thank the Presiding Officer for coming to the floor and speaking out on this, and I hope there are enough people in this body who recognize that virtually everything women have gotten in history has been the product of a fight, and this is one of those.

I yield the floor.

The PRESIDING OFFICER (Mr. CARDIN). The Senator from New Hampshire.

Mr. GREGG. Mr. President, I ask unanimous consent that the next Republican speaker be the Senator from Louisiana, Senator VITTER, to be recognized as a member of the Senate at this time.

Mr. GREGG. Mr. President, at this point I rise to speak generally about...
the bill and specifically about this Medicare proposal—the proposal in the bill and the motion that has been offered by Senator MCCAIN, which I think is an excellent idea.

Let's start with the size of this bill. It is estimated that we would be considering a bill of this size and not have had more time to take a look at it, but the bill itself—and I am glad that the chairman of the Finance Committee has essentially agreed with this earlier today—costs $2.5 trillion when it is fully implemented—$2.5 trillion. When my budget staff took a look at this bill—and we only had a brief time to do it, obviously, last week—and came up with that number, people on the other side of the aisle said, regrettable: No, that is a bogus number. The number is $840 billion, it is not a $2.5 trillion bill. However, it is $2.5 trillion when it is fully implemented. When the programmatic activity of this bill is under full steam, over a 10-year period, it will cost over $2.5 trillion. That is huge—huge.

In an earlier colloquy, I heard the chairman of the Finance Committee—who does such a good job as chairman—make the point: Well, it is fully paid for. It is fully paid for in each 10-year period. That is true, literally. I give him credit for that. But two questions are raised by that fact. The first is this: Why would you expand the Federal Government by $2.5 trillion when we can’t afford the government we have?

The resources that are being used to pay for this, should they ever come to fruition, are resources which should probably be used to make Medicare solvent or more solvent or, alternatively, to reduce our debt and deficit situation, as we confront it as a nation. We know for a fact that every year for the next 10 years—even before this bill is put in place—we are going to run a $1 trillion deficit. That is why we have raised the interest rate 1 percent, because that is what President Obama has suggested. We know for a fact that our public debt is going to go from 35 percent of our gross national product up to 80 percent of our gross national product within the next 6 years without this bill being passed. We know we are in a position where we are headed down a road which is basically going to hand to our children a nation that is fiscally insolvent because of the amount of debt put on their back by our generation through spending and not paying for it.

So why would we increase the government now by another $2.5 trillion when we can’t afford the government we have? That is the question I think we have to ask ourselves. Isn’t there a better way to try to address the issue of health care reform without this massive expansion of a new entitlement that is going to cost such an extraordinary amount of money and dramatically expand Medicaid, which is where most of the spending comes from in this bill—a massive expansion of Medicaid and a massive new entitlement created that we don’t have today?

This bill, when it is fully implemented, will take the size of the Federal Government from about 20 percent of GDP or a little less—where it has historically been in the post–World War II period—up to about 24 or 25 percent of GDP. To accomplish that, and claim you are not going to increase the deficit, requires a real leap of faith. Because it means that to pay for this and this by the McCaskill motion is so important—you are going to have to reduce Medicare spending by $1 trillion, when this bill is fully implemented—$1 trillion over a 10-year window. In fact, during the period from 2010 to 2029, Medicare spending will be reduced in this bill by $3 trillion.

Those dollars will not be used to make Medicare more solvent. And we know we have serious problems with Medicare. Those dollars will be used to create a brand new entitlement and to dramatically increase the size of government for people who do not pay into the hospital insurance fund; for people who have not paid Medicare taxes, for the most part but, rather, for a whole new population of people going under Medicare. There is someone getting this new entitlement under the public plan. So if you are going to reduce Medicare spending in the first 10 years by $350 billion, and the second 10 years fully implemented—there is some overpayment cut in Medicare—fully implemented, $1 trillion, and then over a 19-year period, the two decades, by $3 trillion, instead of using those monies—those seniors’ dollars—to try to make Medicare more solvent, they are going to be used for the purposes of expanding and creating a new entitlement and expanding Medicaid.

This is hard to accept as either being fair to our senior population or being good policy from a fiscal standpoint. Why? Because, why do we want to increase Medicare and then take those moneys and basically try to make Medicare a little more solvent with it. We got no votes from the other side of the aisle—none, zero—on that proposal.

Now they come forward with a representation that they are going to reduce Medicare spending and benefits to seniors by $3 trillion over the next 20 years and $600-some-odd billion over the next 10 years, and they expect this not to be taken seriously? Of course not. This is all going to end up being unpaid-for expenditures in expansion of these programs.

These brand new entitlements that are being put in this bill and this expansion of other entitlements that do not deal with Medicare, by the way, are going to end up being in large part paid for by creating more debt and passing it on to our children. As I mentioned earlier, there is about $70 trillion in unfunded liability just in the Medicare and Medicaid accounts, to say nothing of the other deficits we are running up around here. Now we are going to throw another huge amount on their backs.

Some percentage of this $2.5 trillion—probably a majority of it—will end up being added to the deficit and debt we are writing out into the outdoors even as we go through it is represented that it is not going to be. The only way you can claim you are going to pay for this, of course, is with these Medicare cuts and
these tax increases that are in this bill, and these fee increases. We are going to spend a little time on the tax increases and fee increases and the speciousness of those proposals, but right now we are focusing on Medicare.

In addition to what we have is a bill that takes government and explodes its size. We already have a government that is pretty big—20 percent of our economy. You are exploding it to 24 percent of our economy, and then you are saying you are going to pay for that by dramatically reducing Medicare spending? It does not make any philosophical sense, and it certainly does not pass the test of what happens around here politically.

In addition, there is the issue of how this bill got to a score in the first 10 years that made it look as if it was more fiscally responsible. I have heard people from the other side. Again, I respect the chair of the Finance Committee for acknowledging that the score of that bill, as implemented, is a $2.5 trillion bill. But a lot of folks are claiming this is just an $843 billion bill, that is all it is in the first 10 years, that it is all it costs. There are so many major budget gimmicks in this bill that the best score that Bernie Sanders would be embarrassed—embarrassed by what this bill does in the area of gamesmanship.

Let’s start with the fact that it begins most of the fees, most of the tax increases, and major of the Medicare cuts in the first year of the 10 years, but it does not begin spending on the new program, the new entitlements, until the fourth and fifth year. So they are matching 4 and 5 years of spending against 10 years of income and Medicare cuts and claiming that therefore there is a balance.

Ironically, it is represented and rumored—and I admit this is a rumor—that originally they were going to start in the third year Medicare under this bill. Of course, nobody knew what the bill was because it was written in private and nobody got to see it. But then they got a score from CBO that said it didn’t work that way, so they simply moved the spending back a year and started it in the fourth year. They sent it back to CBO, and CBO said: If you take a year of spending out in the 10 years and you still have the 10 years of income from the taxes, fees, and cuts in Medicare, you get a better score. We will give you a better score. You will get closer to balance. It is a pretty outrageous little game of hide the pea under the shell.

This is probably the single biggest in my experience, and I have been on the Senate Budget Committee for quite a while—in my experience, it is the single biggest gaming of the budget system I have ever seen around here. But it is not the only one; there is something here called the CLASS Act.

Mr. HATCH. Will the Senator yield?

Mr. GREGG. I will be happy to yield to the Senator from Utah for purposes of a question.

Mr. HATCH. What is the current cost of our health care across the board in this country, without this bill?

Mr. GREGG. It is about 16 to 17 percent of our gross national product.

Mr. HATCH. That is $2.5 trillion?

Mr. GREGG. No, that is not correct. Mr. HATCH. The Senator is saying they are going to add, if you extrapolate it out over another 10 years, $2.5 trillion.

Mr. GREGG. It takes the spending from 16 to 17 percent to about 20 percent of GDP.

Mr. HATCH. If I understand my colleague correctly, he is saying, to reach this outlandish figure of $843 billion, literally they do not implement the program until 2014 and even beyond that to a degree, but they do implement the tax increases?

Mr. GREGG. The Senator from Utah, of course, being a senior member of the Finance Committee, is very familiar with those numbers, and that is absolutely correct.

Mr. HATCH. Is that one of the budget gimmicks my colleague is talking about?

Mr. GREGG. I think that is the biggest in the context of what it generates in the way of Pyrrhic, nonexistent savings because it basically says we are really not spending—because it doesn’t fully implement the plan in the first year, it says we are not spending that much money. In fact, we know that when it is fully implemented, it is a $2.45 trillion not a $840 billion bill.

Mr. HATCH. Am I correct that the Democrats have said—and they seem to be unified on this bill—that literally this bill is budget neutral? But as I understand it, in order to get to the budget neutrality, they are socking it to a program that has about $38 trillion in unfunded liabilities called Medicare to the tune of almost $500 billion or $5 trillion in order to pay for this? Am I correct that, No. 2, you are going to lose out when they start taking $500 billion out of Medicare? And what are they going to do with that $500 billion? Are they going to put it into something else? Are they using this just as a budgetary gimmick? What is happening here? As the ranking member on the Budget Committee today, you really could help all of us understand this better.

Mr. BAUCUS. Will the Senator yield for a question?

Mr. GREGG. If I can first answer the question of the Senator from Utah, and then I will be happy to answer the chairman of the Finance Committee.

The Senator from Utah basically is correct in his assumption. Essentially, they are claiming an approximately $100-some-odd billion savings in Medicare over 10 years which they are then using to finance the spending in this bill over the last 5 years, 5 to 6 years of the 10-year window. In the end, after you know, you do it this way and you only slowly and over time fully implement the Medicare cuts, it represents $3 trillion of Medicare reductions over a 20-year period.

Where does it come from? It comes from two different accounts, primarily. One is, just about anybody who is on Medicare Advantage today—about 25 percent of those people will probably completely lose their Medicare Advantage insurance, and it is 12,000 people in New Hampshire, 10,000 people. Mr. HATCH. How many people on Medicare are on Medicare Advantage?

Mr. GREGG. I believe 11 million people.

Mr. HATCH. That will be what percentage of people on Medicare?

Mr. GREGG. About 25 percent of those people will lose their Medicare insurance under this proposal, mostly in rural areas. And second, because there is $160 billion of savings scored. You can’t save that type of money in Medicare Advantage unless people don’t get the Medicare Advantage advantage.

Second, it comes in significant reductions in provider payments. How do provider payments get paid for when they are cut? I ask the Senator from Utah. I suspect it is because less health care is provided.

Mr. HATCH. How does that affect the doctors?

Mr. GREGG. It certainly affects the hospitals, and it probably affects the doctors. I have heard the Senator from Montana say they are going to straighten out the doctor problem down the road, but this is another $250 billion that doctors won’t be sure they know where they are going to get the money from. But, yes, it would affect, in my opinion, all providers—doctors, hospitals, and other people who provide health care to seniors. You cannot take $450 billion out of the Medicare system and not affect people’s Medicare.

Mr. HATCH. Am I wrong in saying Medicare is already headed toward insolvency and that it has up to almost $38 trillion in unfunded liability over the years for our young people to have to pay for?

Mr. GREGG. The Senator from Utah is correct again. The Medicare system is headed toward insolvency, and it goes cash-negative in 2013, I believe—maybe it is 2012—in the sense that it is paying out less than it takes in, and it has an unfunded liability that exceeds, actually, $38 trillion now. I think it is up around—

Mr. HATCH. Then how can our friends on the other side take $3 trillion out of Medicare, which is headed toward insolvency, to use for some programs they want to now institute anew?

Mr. GREGG. I think the Senator from Utah has asked one of the core questions about this bill. Why would you use Medicare savings, reductions in Medicare benefits, which will definitely affect recipients, for the purposes of creating a new program rather than for the purposes of making health care more affordable? Do you want me to do that in the first place? And are these savings ever going to really come about? One wonders about that also.
Mr. HATCH. I heard someone say today on the floor—I don’t know who it was. I can’t remember—that Medicare Advantage really isn’t part of Medicare. Is that true?

Mr. GREGG. Actually, I would yield to the Senator from Utah on that issue—not the floor but yield on that question because I think the Senator from Utah was there when Medicare Advantage was drafted as a law.

Mr. HATCH. I am there in the Medicare modernization conference, along with the distinguished chairman of the committee, Senator BAUCUS, and others, when we did that because we were not getting health care to rural America. The Medicare Advantage plan didn’t work. Doctors would not take patients. Hospitals could not pay; they could not take patients. There were all kinds of difficulties in rural America. So we did Medicare Advantage, and all of a sudden we were able to take care of those people, it costs a little more, but that is because we went into the rural areas to do it.

But this would basically decimate Medicare Advantage, wouldn’t it, what is being proposed here? And that is part of Medicare.

Mr. GREGG. I believe it is a legal part of Medicare, Medicare Advantage.

Mr. HATCH. No question about it.

Mr. GREGG. And this would have a massively disruptive effect on people who get Medicare Advantage because you are going to reduce it—the scoring is there will be a reduction in Medicare Advantage payments of approximately $102 billion. It is, and there is no way you are going to keep getting the advantages of Medicare Advantage if you have that type of reduction in payments.

Mr. HATCH. How can they take $19 trillion out of Medicare? That is not all Medicare Advantage. Medicare Advantage is only part of that, the deductions they will make there. But how can they do that and still run Medicare in a way that is constructive, decent, and honorable fashion?

Mr. GREGG. If the Senator will allow me to respond, the problem here is we have rolled the Medicare issue into this major health reform bill—or the other side has—and they have used Medicare as a piggy bank for the purposes of trying to create a brand new entitlement which has nothing to do with senior citizens. Yes, Medicare needs to be addressed. It needs to be reformed. The benefits probably has to be reformed. But we should not use those dollars for the purposes of expanding the government with a brand new entitlement. We should use those dollars to shore up Medicare so we don’t have this massive deficit in the future.

Mr. HATCH. You mean they are not using this $500 billion to shore up Medicare and to help it during this period of possible insolvency with a $36 trillion unfunded liability? They are not using it for its purposes?

Mr. GREGG. That is correct.

Mr. HATCH. For what purpose are they using it?

Mr. GREGG. They are using to fund the underlying bill, and the underlying bill expands a variety of initiatives in the area of Medicaid and in the area of a brand new entitlement for people who are uninsured to subsidize the government payments.

Mr. HATCH. You were going to talk about the CLASS Act.

Mr. GREGG. The CLASS Act is another classic gimmick of budgetary shenanigans which I would like to speak to, briefly. I know the Senator from Montana had a question or maybe he has gone past that point and we have answered all his questions. I can move on to the CLASS Act.

Mr. BAUCUS. I would like to hear you talk about the CLASS Act. I am no fan of the CLASS Act myself so why don’t you proceed.

Mr. GREGG. I thank the Senator for his forthrightness on that. The CLASS Act needs to be explained. It is a great title. It is a wonderful “motherhood of titles.” We attach them to things and then suddenly they take on a persona that has no relationship to what they actually do. The CLASS Act is a long-term care insurance program which will be government run. It is another takeover of private sector activity by the Federal Government. But what is extraordinarily irresponsible in this bill is, we all know in long-term care insurance that you buy it when you are in your thirties and you probably don’t buy it when you are in your twenties. You buy it in your thirties, forties, and fifties. You start paying in premiums then. But you don’t take the benefits. The cost of those insurance products don’t inure to the insurer until people actually go into the retirement home situation, which is in their late sixties and seventies, most likely eighties in our culture today, where many people are working well into their seventies and then 30 or 40 years later, they start to take it.

What has happened in this bill, which is a classic Ponzi scheme—in fact, ironically, the chairman of the Budget Committee did call it a Ponzi scheme, the Senator from North Dakota, Mr. CONRAD—they are scoring these years when people are paying into this new program and, because the program doesn’t exist, everybody pays into it. The, standing on the beneficaries of that program aren’t going to occur until probably 30 or 40 years later. They are taking all the money that is paid in when people are in their thirties, forties, fifties, and sixties as premiums. They are taking that money and the theory is, as revenue under this bill and they are spending it on other programmatic initiatives for the purposes of claiming the bill is balanced. It adds up to about $212 billion over that 20-year period, 2010 to 2030.

OK. So you spend all the premium money. What happens when these people do go into the nursing home, do require long-term care when they become 75, 80, 90 years old? There is no money. It has been spent. It has been spent on something else, on a new entitlement, on expanding care to people under Medicaid, on whatever the bill has in it. So we are going to have this huge bill that is going to come due to us one more time. We already are stickling them with $12 trillion of debt right now, and we are going to raise the debt ceiling, sometime in the next month, so I don’t know what it is going to be, but I have heard rumors it may be as high as $3 more trillion. Now we have another $9 trillion of debt coming at us just by the budgets projected for the next 10 years. Now we are going to, 30 years from now, have this huge bill come in as the people who decided to buy into the CLASS Act suddenly go into the retirement home. There will not be any money there for them. It is gone. It will have been spent by a prior generation to make this bill balanced.

The CLASS Act has been described as a Ponzi scheme relative to its effect on the budget. It is using dollars which should be segregated and protected under an insurance program. If this were an insurance company, for example, they would actually have to invest those dollars in something that would be an asset which would be available to pay for the person when they go into the nursing home so they are actuarily sound. But that is not what happens under this bill. Under this bill, those dollars go out the door as soon as they come in for the purposes of representing that this bill is in fiscal balance. It is not. It is not in fiscal balance, obviously.

Even if you were to accept these incredible activities of budgetary gimmick, the fundamental problem with this bill is that grows the government by $2.5 trillion, and we can’t afford that when we already have a government that well exceeds our capacity to pay for it. Inevitably, we will pass on to the young, the young people, they go into their earning careers and raise their families, a government that is so expensive, they will be unable to buy a home, send their kids to college or do the things they wish to do that give one a quality of life.

I have certainly taken more than my fair share of time at this point. The Senator from Louisiana was going to go next.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, it has been a very interesting discussion, listening to the Senator from New Hampshire. Several points. One, the underlying bill is clearly not a net increase in government spending on health care.

The numbers are bandied about by those on the other side—$1 trillion, $2.5 trillion, et cetera. I do acknowledge and thank the Senator from New Hampshire for asking for the numbers to be paid for. He did say that. He did agree this is all paid for. So I just hope when other Senators on that side of the aisle...
start talking about this big cost, $1 trillion, $2 trillion, whatever; that they do admit it is paid for. The ranking member of the Senate Budget Committee flatly said: Yes, it is all paid for. I would hope other Members on that side of the aisle heed the statement of the Senator from New Hampshire, ranking member of the Senate Budget Committee, for saying it is all paid for.

But don’t take my word for it or his word. It is what the CBO says. In fact, let me note a letter to Senator Reid not too long ago:

The CBO expects that during the decade following the 10-year budget window, the increases and decreases in Federal budgetary commitment to health care stemming from this legislation would roughly balance out so that there would be no significant change in that commitment.

That is, a commitment to health care, to government health care spending, no change basically. It is flat. Although it is a little better than flat because the subsequent CBO letter has said the underlying bill achieves about $330 billion in deficit reduction over 10 years and one-quarter of a percent of GDP reduction over the next 10 years. The Senator from New Hampshire talks about large deficits this country is facing. That is true. Frankly, all of us in the Senate have a responsibility to try to reduce that deficit as best we can. We do very well. We do very, very well. Bear in mind, this underlying health care bill helps reduce the budget deficit. Sometimes people on the other side like to suggest that $1 trillion over 10 years will add to the budget deficit. Again, we have definitely established it does not add to the budget deficit at all, not one thin dime.

In addition, we actually reduce the budget deficit through health care reform, through this underlying legislation. The Medicare trust fund is in jeopardy. In part, because baby boomers are retiring more but also because health care costs are going up at such a rapid rate. That is health care costs for everybody. It is health care costs for me, for every senior, for businesses. Let’s not forget, we spend in America about 60 percent more per person on health care than the next most expensive country, about 50 to 60 percent more per person. The trend is going in the wrong direction. We are going to spend about $33 trillion in America on health care over the next 10 years. That is going to be somewhat evenly divided between public expenditures and private. Every other country in the world has figured out ways to limit the rate of growth of increase in health care spending. We haven’t. We are the only industrialized country—in fact, developing country—that hasn’t figured out how to get some handle on the rate of growth of increase in health care spending. We haven’t. We are the only industrialized country—in fact, developing country—that hasn’t figured out how to get some handle on the rate of growth of increase in health care spending. We haven’t. We are the only industrialized country—in fact, developing country—that hasn’t figured out how to get some handle on the rate of growth of increase in health care spending. We haven’t.

One could say: Gee, let’s forget about it. Just let the present trend continue. We all bandy about different figures. One is fond of at least remembering the average health care insurance policy in America today costs about $13,000. If we do nothing over 8 years, it will be $30,000. That is a much higher rate of increase than income for America. It is seven times the annual wages of the average American and what they are paying on health care will widen all the more if we do nothing. We have to do something. This legislation is a good-faith effort to begin to get a handle on the rate of growth of spending in this country.

The Senator from New Hampshire was being honest, frankly. Some on the other side are being not quite so honest. He is basically saying: Yes, it is true we are not cutting beneficiary cuts, although he talks about Medicare Advantage. Let me point out that there is nothing in this legislation that requires any reductions in any beneficiary cuts. In fact, guaranteed benefits under Medicare are expressly not to be cut under the language of this bill. The portion we are talking about is Medicare Advantage. The fact is, there is nothing in this bill that requires any cuts at all in Medicare Advantage payments. Those Medicare Advantage payments in addition to the guaranteed Medicare payments, such as gym memberships, things such as that which are not part of traditional Medicare.

Why is there nothing in there that requires cuts for those extras? That is because the decision on what benefits or what extras Medicare Advantage plans have to give the guaranteed benefits, that is by law. But the decision as to what extras should go to Medicare providers is not being paid, the guaranteed Medicare payments, those corporate officers of those plans. They can decide what they want to do. They can make that decision not to cut, not to cut, nothing whatsoever.

That is a very basic, fundamental, values question I think this country should face; that is, do we want to set up a system where virtually all Americans have health insurance? We are the only industrialized country in the world that does not have a system where its citizens have health insurance—the only industrialized country
in the world. It is a very basic question. I think we should ask ourselves as Americans: In every other industrialized country, health insurance, health care is a right. That is the starting point. In every other country that has a health care system, health care is a right. That is the point that everybody should have health care.

Of course, it is true, people are different. Some are tall, some are short. Some are very athletically endowed, some are not. Some are not smart, some are not so smart. But health care does not care—that is a way to put it—whether you are dumb, smart, tall, skinny. It affects everybody: that is, diseases affect everybody, and everybody needs health care regardless of your station in life, regardless of your income, regardless of whether you are an egghead, you are brilliant, or an athlete. It makes no difference whatsoever. We are Americans.

I frankly believe other countries on that point have it right; that is, that they treat all their citizens basically equally because disease is indiscriminate—who is going to get disease—accidents are indiscriminate—who is going to get in an accident—and so forth. So we could spend $400 billion to $500 billion and reduce the deficit with it and forget any health insurance coverage. That would be an option. That is a legitimate question we could ask ourselves. I frankly believe the better choice is the one that does extend the salvency of the trust fund, and help set up a way, help set up a system so all Americans have health insurance. We do it in a way that reduces the budget deficit. We do it in a way that reduces the budget deficit in the first 10 years and also in the next 10 years.

I again repeat, if trimming the rate of growth of provider payments was OK back in 1997—that was twice as much as today—to extend the sal- vency of the Medicare trust fund—why isn’t it OK today to do half as much to extend the life of the trust fund, in this case for 5 more years, and at the same time help provide health insurance benefits for people who deserve it?

Let’s not forget, hospitals want us to do this. They want everyone to have health insurance. Doctors want us to have a system where everybody has health insurance, whether it is Med- icaid or if it is private health insurance. Whether it is Medicare or it is private health insurance, whether it is Med- icaid or it is private health insurance. All the providers want it. The pharmaceutical industry does, the home health industry does, the hospice industry does. The durable medical equipment manufacturers want it. They all want it because they know it is the right thing to do. They also know they are not going to get hurt.

I heard some reference here that some HHIs actuary, commenting on the House bill, said, oh, gee, it might scare providers and whatnot, but we actually got a report from information which showed that letter—that actuary ad- mitted it is extremely variable, what he came up with. There are lots of fac- tors he did not take into consideration. I also have statements from hospital administrators saying no way are they going to be allowed.

And, man, we need about a week or so to talk about all the reforms in this bill that are so important so we have a better health care system focusing on provider reimbursement reforms.

... Most importantly, the legislation does not reduce any guaranteed Medicare benefits.

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No. 2, for women aged 50 to 74, the previous recommendation was to get a routine mammogram to screen against breast cancer every year. The task force, 2 weeks ago, stepped back from that and said: No, every other year is probably good enough. So not every year.

No. 3, for women over the age of 75, the previous recommendation was to have routine screening at least every 2 years. The new recommendation from the task force steps back from that and says: No, we do not recommend routine screening over the age of 75.

And, No. 4, the task force 2 weeks ago said: We no longer recommend breast self-examination by women to detect lumps to get treatment early. We do not believe in that. We step back from that.

Those are four huge changes in their previous recommendations. Those are four controversial recommendations completely at odds with what I believe is the clear consensus in the medical community and the treatment community.

When I first read about these new U.S. Preventive Services Task Force recommendations around November 17, I had the immediate reaction I just enunciated, but I said: I am not an expert. I am not a doctor. I am not a medical expert. I want to hear from folks who are much closer to this crucial issue. So I convened a roundtable discussion in Baton Rouge, LA. We had it on Monday, November 23. It was at the Mary Bird Perkins Cancer Center. They were very kind to host it. It was cohosted by Women’s Hospital in Baton Rouge. We had a great roundtable discussion featuring a lot of different people, including oncologists, other MDs, other medical experts, and including, maybe most importantly, several breast cancer survivors. We had a great roundtable discussion featuring a lot of different people, including oncologists, other MDs, other medical experts, and including, maybe most importantly, several breast cancer survivors. I want to hear from experts and oncologists is so clear that we should have a Republican alternative to that Mikulski amendment.

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this year are a huge step backwards, a huge mistake. That is what the experts are saying. That is what oncologists are saying. That is what cancer specialists are saying. That is what leaders of cancer associations are saying. That is what, perhaps most importantly, breast cancer survivors are saying.

We can look at history in this country in the last several decades and happily point to real progress in this fight. One of the causes of that good news, that progress, is the decision since the late 1960s when my wife Wendy’s mom passed away from breast cancer, clearly one of the underlying reasons, clearly one of the leading causes is dramatic improvement in this prevention and screening, using mammography, also educating about self-examination.

So, again, I have this second-degree amendment. My hope and my goal would be that this language, which should be noncontroversial, would be accepted as well as any Republican alternative, and that whatever happens in terms of those votes, we come together and make crystal-clear that this task force of unelected bureaucrats—didn’t include a single oncologist, way—made a very big mistake and we are going to make sure those new recommendations don’t have any impact in terms of law, in terms of government programs, in terms of legal impact on insurance companies.

Let me talk, for a moment, specifically about the Mikulski amendment and why it is so important. It will ensure that women are able to access needed preventive care and screenings, requiring that recommended services be covered at no cost to women. We know that to get preventive screenings and care screenings so seniors will pay no copay. It is not cutting Medicare and services, as my friends on the other side say—all those who are opposed to it—as my friends on the other side say—all those who are opposed to it.

One of the things this legislation does for Medicare beneficiaries is it will begin to provide these preventive care screenings so seniors will pay no copay. It is not cutting Medicare and services, as my friends on the other side say—all those who are opposed to it.

Let me go back to why the Mikulski amendment makes so much sense. All health care plans would cover comprehensive women’s preventive care and screenings, requiring that recommended services be covered at no cost to women. We know that to get preventive screenings and care—if we make them at no cost, the chances of people getting them are significantly higher. More than half of women delay often enough today, and that the rates for women would be comparable to the rates for men. That is, again, why the Mikulski amendment is so important.

That is why I would hope Senator VITTER, as he is pushing for assistance for women with breast cancer—I applaud him for that—would go deeper than just dismissing the recommendations of one government commission and that, in fact, he would advocate for better testing, more frequent testing for women who are not getting tested often enough today, and that the rates for women would be comparable to the rates for men. That is, again, why the Mikulski amendment is so important.

I will repeat: The health reform legislation as is will finally put an end to discrimination that charges women significantly higher premiums because they have had children.

It is considered a preexisting condition by some insurance companies if a woman had a C-section because she might get pregnant again and she is going to have another C-section and that costs more. A woman with a C-section has a preexisting condition. A woman who has been—in some cases, with some insurance companies’ policies—victimized by domestic violence has a preexisting condition because the boyfriends, the husbands or whoever hit her the one time, the insurance companies would suggest, is going to do it again. So she has a preexisting condition. What kind of health care system is that?

That is why I suggest Senator VITTER support the Mikulski amendment and support this legislation. In fact, it will put rules on insurance policies so people will be treated in a different way than they have been in the past.

One of the problems is that if a woman who don’t have insurance are 40 percent more likely to die of breast cancer than those with insurance. At the same time, as the Presidential Officer knows, in the State of Maryland, women typically pay more for their insurance than men do on the average.

So if we are going to do this right, it means we need insurance reform, which is why I support doing more preexisting conditions, no more men and women who have their insurance canceled because they got too sick last year and had too many expenses and the insurance companies practiced reinsurance. No more if I have insurance and if I have a child born with a preexisting condition do I lose my insurance.

I come to the floor pretty much every day reading letters from people in Ohio from Galion and Gallipolis and Lima, all over my State. Typically, people were pretty happy with their insurance if they had written me a year ago, these people. But today these people writing found out their insurance doesn’t cover what they thought it did. They end up losing their insurance because of a preexisting condition. They can’t get insurance because they once had breast cancer. They have had this discrimination against women of gender or geography or disability. That is what is important about the bill and what is important about the Mikulski amendment.

That is why I would hope Senator VITTER, as he is pushing for assistance for women with breast cancer—I applaud him for that—would go deeper than just dismissing the recommendations of one government commission and that, in fact, he would advocate for better testing, more frequent testing for women who are not getting tested often enough today, and that the rates for women would be comparable to the rates for men. That is, again, why the Mikulski amendment is so important.

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That is why I suggest Senator VITTER support the Mikulski amendment and support this legislation. In fact, it will put rules on insurance policies so people will be treated in a different way than they have been in the past.
In 2009, some 40,000 women will lose their lives to breast cancer; 4,000 breast cancer deaths, one-tenth of those could have been prevented by increasing these preventive screenings. These kinds of mammograms, this preventive care, and annual mammograms visits will be covered for free for women.

This amendment would broaden the comprehensive set of women’s health services that health insurance companies must cover and pay for.

Fourth, we must ensure that women of all ages are able to receive annual mammograms, covered by their insurer. It would encourage coverage of pregnancy and postpartum depression screenings, Pap smears, screenings for domestic violence, and annual women’s health screenings. It makes so much sense. It would save the lives of women, and it means women would suffer from a lot less illnesses. It will save money for the health care system because these illnesses will be detected much sooner, and women will receive the kind of care they should. That is what this whole legislation is about and what the Mikulski amendment will add to.

This amendment will remove any and all financial barriers to preventive care, so we can diagnose diseases and illnesses early—when we have the best chance at being able to save lives, obviously.

Understand again, this legislation and the Mikulski amendment are supported by the National Organization for Women, the National Partnership of Women and Families, the American Cancer Society Cancer Action Network, and all kinds of women’s organizations. They understand this is the best thing for women in this country.

I hope the Senate can proceed to a vote on this amendment. I hope my Republican colleagues will not just talk about the bad decision of this Commission—but actually do something about it, something substantive, and give women in this country a fairer shake from health care insurance companies and cover these preventive services and cancer screenings. It will make a big difference if we can move forward and expand preventive health care services to women.

I yield the floor.

The PRESIDING OFFICER (Mr. Menendez). The Senator from Oklahoma is recognized.

MR. COBURN. Mr. President, I wish to pick up where Senator Brown left off. I will describe one of my real patients, but I will not use her real name. I will call her “Sheila.” Sheila was 32 years old. She came in with a breast mass. I examined it and thought it was a cyst. I sent her to get an ultrasound, which confirmed a cyst. OK. We did a mammogram to make sure. The mammogram said it looks like a cyst. The standard for everybody with a cyst is to watch it expectantly, unless it is painful, because 99 percent of them are benign cysts. I had the good fortune to do a needle drainage on her cyst 3 days after she had her mammogram. There were highly malignant cells within the cyst. She has since died.

The reason I wanted to tell the story about a patient like I did Sheila is that the Senator from Ohio, in supporting the Mikulski amendment, doesn’t recognize is, we don’t allow the Preventive Services Task Force to set the rules and guidelines. We do something worse: We let the Secretary of HHS set the guidelines.

The people who ought to be setting the guidelines are not the government; they are the professional societies that know the literature, know the standards, care, know the best practices; and, in fact, the Mikulski amendment doesn’t mandate mammograms for women. It leaves it to HRSA, the Health Resources Services Administration, which has no guidelines on it today whatsoever.

So where are we saying with the Mikulski amendment is, we want the government to once again, decide—all of us are rejecting what the Preventive Services Task Force has said, but instead we are going to shift and pivot and say we will let HRSA decide what your care should be.

The other aspect of the Mikulski amendment I fully agree with. I don’t think there ought to be a copay on any preventive services. I agree 100 percent. But the last place we ought to be making decisions about care and process and procedure is in a government agency that, No. 1, is going to look at cost as much as at preventive effectiveness.

If the truth be known, the Preventive Services Task Force, from a cost standpoint—as a practicing physician, I know how to read what they put out—from a cost standpoint, it is exactly right. From a clinical standpoint, they are exactly wrong, because if you happen to be under 50 and didn’t have a screening mammogram and your cancer was missed, you are 100 percent wrong. You see, the government cannot practice medicine effectively. What we are trying to do in this bill throughout is have the government practice medicine, whether it is the comparative effectiveness panel or the Medicare Payment Advisory Commission.

What we have asked is for the government to make decisions.

Let me tell you what that is. That is the government standing between me and my patient. It is denying me the ability to use my knowledge, my training, my 25 years of well-earned gray hair, and combine that with my patient’s history, social history, psychological history, where it might be important, and clinical science, and me putting my hand on a patient such as I did Sheila. Most physicians would never have stuck a needle in that cyst, and she would have lived 12 years that she lived. She would have lived 1 or 2 years. But she got 12 years of life because clinical judgment wasn’t deferred or denied by a government agency.

There is a wonderful member of the British Parliament who happens to be a physician. When we were debating the issue of the comparative effectiveness panel, which mandated what HRSA or the Secretary does, I asked him: What about the national institute of comparative effectiveness in England? Here is what he said: As a physician, it ruins my relationship with my patient because no longer is my patient 100 percent my concern. Now my patient is 80 percent my concern and the government is 20 percent of my concern. So what I do is I take my eye off my patient 20 percent of the time to make sure I am complying with what the national institute of comparative effectiveness says—even if it is not in my patient’s best interest.

When we pass a bill that is going to subterfuge or undermine the advocacy of physicians for their patient, the wonderful health care we have in this country will decline. There are a lot of other things about the bill I don’t agree with. But the No. 1 thing, as a practicing physician, that I disagree with is the very fact—the thing I am most opposed to as a practicing physician—I like best practices. I use Vanderbilt in my practice. I like them. They make me more efficient and make me a better doctor. But they are not mandated for me when I see somebody. I am an advocate for my patient. I get to go the other art of medicine I get to go. I am an advocate for my patient. That is why I am the best advocate for my patient.

What we have in this bill is what we passed with the stimulus bill, the comparative effectiveness panel—which is utilized in this bill—and we have the Medicare Payment Advisory Commission saying you have to cut. Where do we cut? Whose breast cancer screening do we cut next year? When we have the comparative effectiveness panel saying you have to cut. Where do we act affirmatively in another way, we are dividing the loyalty of every physician in this country away from their patients. They are no longer a 100-percent advocate for their patients. This is a government-centered bill. It is not a patient-centered bill.

Going back to the Mikulski amendment and what will come with the Murkowski amendment, the Murkowski amendment is far better. It does everything that the Murkowski amendment says but doesn’t divide the loyalty or advocacy of the physician. Here is what it does. The Murkowski amendment says nobody steps between you and your doctor—nobody, not an insurance company, not Medicare or Medicaid. We use as a reference the professional societies in this country who do know best, whether it be for mammograms and the American College of Surgeons, the American College of OB/GYNs, the American College of Obstetrics and Gynecology, the American Academy of Internal Medicine or the American College of Physicians, which have come to a consensus in terms of what best practices are but...
Mr. COBURN. I do embrace is most people who go in for exercise and limit the ability for us to practice medicine, which is what this bill does—the government steps in this bill, there are new programs under the Mikulski amendment is not included? Because what we have done under the Mikulski amendment is not a government program, it is a government program, it is a preventive measure. Why were they done for one group but we will not do the other. If we decide the government is going to practice medicine, which is what this bill does—the government steps in to practice medicine, which is what this bill does. This is a matter of fact, we are paying too much money for Medicare Advantage payments. The differential from $135 to—I will read it to the chairman. The chairman of the Finance Committee has said we do not truly cut Medicare Advantage, that the services are not reduced. The chairman's own bill, on page 869, subtitle C, part C—I won't go through reading it—reduces Medicare Advantage payments. The differential from $135 to—I will read it to the chairman. The chairman is shaking his head. Let me read it to him. Let me also reference what CBO has said. I will be happy to yield to the chairman if he wants to talk now. Mr. BAUCUS. As soon as I get the page number, I guess I would like to ask the Senator from Oklahoma a question.

Mr. COBURN. I will be happy to yield for a question.

Mr. BAUCUS. What page?

Mr. COBURN. Page 869, subtitle C, part C.

Mr. BAUCUS. I don't have it with me right now, but there are no required reductions in fringes or extras—Mr. COBURN. No required reductions in what?
Mr. BAUCUS. Fringe benefits, such as gym memberships, and extras such as that. The bill basically provides that there be no reductions in guaranteed Medicare payments. There is a long list of what guaranteed Medicare payments are.

Even the Medicare Advantage companies, which are private companies with officers and they have stockholders—they have to report to their board of directors, and they have all these administrative costs, very huge admin costs. The reductions to Medicare Advantage—the application of reductions to Medicare Advantage plans are at the discretion of the officers. The officers can decide they are not going to cut the fringes; that is, the fringes and the extras that are beyond, in addition to the guaranteed Medicare benefits.

ESTIMATED EFFECTS OF THE MEDICARE ADVANTAGE (MA) PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ON ENROLLMENT IN MA PLANS AND ON FEDERAL SUBSIDIES FOR ENROLLEES IN MA PLANS OF BENEFITS NOT COVERED BY MEDICARE

Under Current Law

<table>
<thead>
<tr>
<th>Enrollment in MA Plans (millions)</th>
<th>Average Subsidy of Extra Benefits Not Covered by Medicare (dollars per month)</th>
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<tbody>
<tr>
<td></td>
<td>2009</td>
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<tr>
<td>Areas with Bids that Average Less Than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector</td>
<td>10.6</td>
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<tr>
<td>Areas with Bids that Average More Than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector</td>
<td>4.7</td>
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<td>Area with Bids that Average More Than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector</td>
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Under the Patient Protection and Affordable Care Act

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<tr>
<th>Reduction in enrollment in MA plans, 2019</th>
<th>Net reduction in Medicare spending 2010–2019 Billions of dollars</th>
<th>Average subsidy of extra benefits not covered by Medicare, 2019 Dollars per month</th>
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<tr>
<td>Areas with Bids that Average Less Than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector</td>
<td>– 18</td>
<td>– 2.6</td>
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<tr>
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<td>Area with Bids that Average More Than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector</td>
<td>– 9</td>
<td>– 0.6</td>
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* The estimate of a $105 billion net reduction in Medicare spending over the 2010–2019 period reflects a $118 billion reduction in Medicare payments that would be offset, in part, by a $13 billion reduction in Part B premiums.

Mr. COBURN. The fact is, if you like what you have, you cannot keep it, for 2.6 million Americans. You can say that is not true. That is what CBO says. Here are their numbers. They sent the report to the chairman.

Mr. BAUCUS. Will the Senator yield?

Mr. COBURN. I will be happy to yield.

Mr. BAUCUS. It is true—first of all, we need to back up. Isn’t it true that the MedPAC commission came to the conclusion that the Medicare Advantage plans are overpaid?

Mr. COBURN. Absolutely. I agree with the chairman.

Mr. BAUCUS. It is also true that it is their recommendation that the Medicare plans overpaid by the amount of 14 percent?

Mr. COBURN. I don’t know the actual amount. I agree with the chairman that they are overpaid.

Mr. BAUCUS. That is true. They are overpaid.

Mr. COBURN. Yes.

Mr. BAUCUS. If they are overpaid, doesn’t that necessarily mean there are reductions in payments attributable to each beneficiary by definition?

Mr. COBURN. I disagree with that.

Mr. BAUCUS. If they are overpaid—

Mr. COBURN. Here is what I would say. This morning, the claim made by the chairman and Senator Dodd is that Medicare Advantage is not Medicare. Medicare Advantage is Medicare law. It was signed into law. It is a part of Medicare. The chairman would agree with that?

Mr. BAUCUS. Absolutely. In 2003, I made the mistake and agreed to give the Medicare Advantage plans way more money than they deserved. And as the Senator from Oklahoma has said, they are overpaid.

Mr. COBURN. I agree with the chairman. You won’t hear that from me. How did we get there? How did we get there? How did we get there, to where they are overpaid? We have an organization called the Center for Medicare and Medicaid Services. They are the ones who let the contract, are they not? They, in fact, are. Twenty-five percent of the overpayment has to be rebated to CMS today; the Senator would agree with that? Seventy-five percent for extra benefits, 25 percent rebate. How did we get to where they are overpaid? Because we have a government-centered organization that is incompetent in terms of how they accomplished the implementation of that bill.

What was said by Senator Dodd this morning—and I confronted him already on it, but it bears repeating—is that the Patients’ Choice Act eliminates the dollars without eliminating the services because it mandates competitive bidding with no elimination in services for Medicare Advantage. So if you want to save money, competitively bid rather than go through eight pages of reductions year by year in the payments that go back to Medicare Advantage.

We have this complicated formula that nobody who listens to this debate would understand. I know the chairman understands it because he helped write it. But the fact is 2.6 million Americans, according to CBO, will see a significant change in their Medicare benefits. Medicare Advantage is Medicare Part C. We have had a kind of a differential made that it isn’t really Medicare. It is Medicare. And 20 percent of the people in this country who are on Medicare are on Medicare Part C—Medicare Advantage—and they like it. And why do they like it? Because most of them don’t have enough money to buy a supplemental Medicare policy to cover the costs that are associated with deductibles and copays and outliers. So I agree with the chairman that Medicare Advantage is overpaid, but I disagree with the way you are going about getting there.

I also disagree with taking any of the money that is now being spent on Medicare Part C and creating another program. I think all that money ought to be put back into the longevity of Medicare.

In case you don’t understand how impactful that is, we now owe, in the next 75 years—actually, we don’t owe it, because none of the Senators sitting here will be around. Our kids are going to get to pay back $44 trillion in money for Medicare we will have spent, that allowed to grow, in fraud, close to $100 billion a year and then did nothing about it. This bill does essentially nothing about that $100 billion a year, or $1 trillion every 10 years. If we were to eliminate that—which this bill does not—we would markedly extend the life and lower the debt that is going to come to our children.

That leads me to the other important aspect of the health care debate. We know when you take out the funny accounting—the Enron accounting—in this bill, and you match up revenues with expenses, you are talking about a $2.5 trillion bill. The chairman of the
Finance Committee readily admits it has it paid for, and CBO says you have it paid for. But how does he pay for it? He pays for it with the 2.6 million people who like what they have today and who are going to lose what they have today. It is paid for by raising Medicare taxes. Then the Medicare taxes he raises he doesn’t spend on Medicare, he spends that on a new entitlement program. Think about what we are doing. Is there a better way to accomplish what is best.

I thank the chairman for indulging me and allowing me to continue this long. I will wind up with a couple of statements and then share the floor with him.

You know, after practicing medicine for 25 years, I know we have a lot of problems in health care, and I appreciate the efforts of the chairman of the Finance Committee to try to find a solution. It is not a comprehensive solution, but it is a solution. And it is a solution that grows the government. It puts the government in charge of health care and creates blind bureaucracies and mandating how they will do it. Wouldn’t it be better to incentize tort reform in the States? Wouldn’t it be better to incentize physicians based on outcomes? Wouldn’t it be better to incentize good behavior by medical supply companies, DME, drug companies, hospitals, physicians, through accountable care organizations, through transparency for both quality and price?

We don’t have any of that in here. What we have is a government-centered role that is played in terms of the mandates, the rules, and regulations.

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health care, and I can’t imagine the impact it is going to have between me and my patients. It is going to severely impact them. Do I want everybody in this country to have available care? Yes; 15 percent of my practice was gratis, for people who had no care, who had no money. That is true with a lot of physicians out there in this country. It is true with a lot of labs. It is true with a lot of hospitals. It is true with a lot of the providers in this country. They are caring people. We are going to put regulations and ropes around them. We are going to mandate rules and regulations, and we, in our arrogant wisdom, are going to tell Americans how they are going to get their health care. I certainly hope not. But I am not thinking about me. I am thinking about our kids and our grandkids.

I will end with one last comment. Thomson-Reuters, in a study put out October of this year—it is a very well-respected firm—their estimate of the $2.4 trillion that we spend on health care per year in this country is that between $600 and $850 billion of it is pure waste. Defensive medicine costs and not between $250 billion to $325 billion by their estimate. Not one thing in this bill to address that—not one thing.

Fraud, there is between $125 and $175 billion per year—insignificant in this bill, $2 billion to $3 billion.

Administrative inefficiency, 17 percent—between $100 and $150 billion wasted on paperwork in health care every year.

Provider errors—that is me—between $75 and $100 billion; that is either wrong diagnosis or failure to treat appropriately. It is the smallest of all.

What are we doing? We are going to tell the providers—the hospitals, the medical device companies, the drug companies, the radiologists, the labs, the physical therapists—we are going to tell them how to do it. That is not where the problem is.

My hope is that the American people will come to their senses and say: Wait a minute. Slow down. Stop. Fix the important things. Fix the worst thing first, the next thing second, the next thing third, the next thing fourth. The unintended consequences of this bill are going to be unbelievable. Nobody is smart enough to figure all this out—nobody. Not on my staff, nobody on the Finance Committee, nobody in Majority Leader Reid’s office can predict what a dysfunctional, broken health care system we have in America.

Sometimes, listening to this conversation on the Senate floor, you would think this is a rather complicated debate. But the heart of this bill is not that complicated. The heart of this bill is that every single American should have affordable, quality health care, and that we can take a model that has worked very well for the Federal employees of our Nation, a model that encourages competition, a model that says let’s create a marketplace where every individual, every small business that currently struggles to get health care and has to pay a huge premium for health care—enable them to join a health care pool that will negotiate a good deal on their behalf.

I think every American who has tried to get health care on their own, every small business that is paying a 15- to 20-percent premium because they don’t have the clout of a large business, understands if they could join with other businesses, if they could join with other individuals, they would get a lot better deal.

Americans understand if there is a large pool of citizens who are seeking health insurance that insurers are going to be attracted to market their goods. We have seen that in the Federal employees system, where insurers come and compete. It turns the tables. It is a very smart move on the part of the insurance companies and it gives the power to the American citizen because now the citizen is in charge. Now the citizen gets to choose between health care providers instead of having to search for one with whom they can possibly get a policy.

I do not find that it is arrogant to try to create a system in which individuals and small businesses get health care that is more affordable. I don’t find that a bill that says every single American is going to find affordable health care, and if they are too poor to afford it we will provide a subsidy to assist them, to get everyone in the door, that is not arrogant. That is saying we are all in this together as citizens and that health care is a fundamental factor in the quality of life. It is a fundamental factor in the pursuit of happiness. It is not arrogant to find for fundamental access to health care.

I rise specifically to address the amendment offered by my good friend from Maryland, Senator Mikulski. The legislation we are considering has many parts that make health care more affordable and available, that expand access; many parts to hold insurance companies accountable. But a big part of health care reform also deals with helping people avoid illness or injury in the first place. That is what Senator Mikulski’s amendment does and why it is so important that it be included in this package.

Preventive screening saves lives. That is a fact. Early detection saves lives. That is a fact. Too many women forgo both because of the cost.

I want to share a story from a physician in Oregon. The physician is Dr. Linda Harris. I am going to quote her story in full. It is not that long. She says:

When Sue was 18 she had a tubal ligation after she gave birth to her only child. As a single mom she did not have the financial resources to have more children. She concentrated on raising her daughter. Sue worked, sometimes 2 jobs at once, but never the kind of job that offered health insurance. But because she had a tubal ligation she did not qualify for our State’s family planning expansion project that provides free annual exams, Pap smears and contraceptive services to many of our clients.

The doctor continues:

Cervical cancer is an entirely preventable disease. Pap smears almost always find it in its preinvasive form, but Sue never came in for a Pap smear or an annual exam. Her lack of affordable access to basic health care proved fatal. When Sue died of cervical cancer her daughter was 13.

That is the completion of the story that the doctor shared. Sue should not be viewed as a statistic in a broken health care system. But, instead, we
should take her story to heart, about the importance of preventive services. Sue is one of 44,000 Americans who die each year because they lack insurance, according to a recent Harvard Medical School study.

Let me repeat that statistic because I think it is hard to get your hands around—44,000 Americans die each year because they lack insurance. I don’t think it is arrogant to say we should build a health care system that gives every single American access to affordable, quality health care. But that 44,000 of our mothers and fathers, our sons and brothers, our daughters, our wives, our sisters—so that 44,000 of them do not die each year because they lack insurance.

Senator Mikulski’s amendment will help keep this tragedy from happening to our families. To put it plainly, it will save lives. It does this by allowing the Health Resources and Services Administration to develop evidence-based guidelines to help bridge critical gaps in coverage and access to affordable preventive health services—the same approach the bill takes to address gaps in preventive services for children. This will guarantee women access to the kinds of screenings and tests that can prevent illnesses or stop them early.

As the American Cancer Society Cancer Action Network notes: Transforming our broken “sick care” system depends on an increased emphasis on detection and early prevention, enabling us to find diseases when they are easier to survive and less expensive to treat.

That last point is also important. Treating illnesses also saves money. With so much emphasis on the cost of health care, we should all agree that it is common sense to include reforms that lower health care costs for all Americans.

I was noticing that her amendment has a long list of organizations stating how important this is—the National Organization for Women, the National Partnership for Women and Families, the Religious Coalition for Reproductive Choice, the American Cancer Society—Cancer Action Network, the National Family Planning and Reproductive Health Association.

I applaud Senator Mikulski for offering this amendment. I urge my colleagues to remember the 44,000 Americans who die every year because they lack insurance, to ensure that they do not have access to preventive services, and to vote to include this important reform.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Ms. MURKOWSKI. Mr. President, I ask unanimous consent I be permitted to engage in colloquy with my Republican colleagues on an amendment I will be discussing.

The PRESIDING OFFICER. Without objection it is ordered.

Ms. MURKOWSKI. Mr. President, there has been a great deal of discussion this week certainly, and last week, with the announcement from the U.S. Preventive Services Task Force, the USPSTF, of their recommendations as they relate to mammograms and recommendation that women under the age of 50 do not need to be screened at that age. Then reach age 50, and then on attaining the age of 50, every other year after that.

When these recommendations came out on November 16, it is fair to say they generated a level of controversy, a level of discussion and a level of confusion around the country by women from all walks of life. For many years now, women have operated under what we knew to be the standards, the protocols. If you had a history of breast cancer in your family, you took certain steps earlier, but the general recommendation was out there. Certainly, the guidelines we had been following, the assurances we were seeking as women were that we would be encouraged to engage in these screenings on an annual basis. They gave us all a level of confidence. When these new recommendations, these new guidelines came out just a couple weeks ago, I do think the level of confusion, the level of anxiety that was raised because of the amendment to focus on some of the new recommendations in the guidelines, in the mammograms, ultrasound, abdominal ultrasound.

I think we learned from the announcement from the USPSTF, the Preventive Services Task Force, that when we have government engaging in the decisions as to our health care and what role they actually play, there is a great deal of concern and consternation. I have heard from many colleagues on both sides of the aisle: That task force was wrong. We think they have made a mistake in their recommendations.

What are we intending to do with this amendment is keep the government out of health care decision-making and allow the spotlight to be shown on the level of prevention coverage that patients will get under their health care plan, rather than relying on unelected individuals, basically individuals who are appointed by an administration to set as part of this panel of 16, on the Preventive Services Task Force. My amendment specifies that all health plans must consult the recommendations and the guidelines of the professional medical organizations to determine what preventive services and benefits should be covered by all health insurance plans.

I know at least those of us who are on the Federal employees health benefits have an opportunity to subscribe to the Blue Cross/Blue Shield plan. This is their booklet that is out for 2010. This is under their standard basic option plan. Turn to preventive care for adults that is covered. They provide, under this particular plan, for screening tests, for diagnostic tests, and screening procedures for colorectal cancer tests, for prostate cancer, cervical cancer, mammograms, ultrasound, abdominal aneurysm. There is a list we can look to.

What we don’t see laid out in this booklet or any of the other pamphlets that outline given plans out there is, OK, for instance, the breast cancer test, is there an age restriction. I am told under Blue Cross there is not. But if you want to operate under the Federal employees health benefits, you select your insurance coverage. In other words, what preventive services, what diagnostic tests, and screening procedures for colorectal cancer tests, for prostate cancer, cervical cancer, mammograms, ultrasound, abdominal aneurysm. There is a list we can look to.

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every 2 years for women between the ages of 21 and 29. The American Society of Clinical Oncology, as to the recommendations for mammography, urges all women beginning at age 40 to speak with their doctors about mammography every year starting at age 40.

As an individual who is looking to make a determination as to what the experts are saying out there, what is being recommended, I would like to know that this information is made available to me to help me make these decisions. What our amendment would require is the plans would be required to provide this information directly to the individuals through the publications they produce on an annual basis. What we are about not only the doctors. It is the specialists who will be recommending what preventative services to cover, not those of us here in Washington, DC, in Congress, not the Secretary of Health and Social Services, who may or may not be a doctor or a medical professional, not a task force that has been appointed by an administration. We are trying to take the politics out of this and put it on the backs of the medical professionals who know and understand this. This is where we want to put the emphasis. This is where we want to be relying on the professionals, not the political folks.

Additionally, my amendment ensures that the Secretary of Health and Human Services shall not use any recommendations made by the U.S. Preventive Services Task Force to deny coverage of any items or services. This is the crux of so much of what we are discussing right now with these latest recommendations that came out by USPSTF. The big concern by both Republicans and Democrats and everyone is the insurance companies are going to be using these recommendations now to deny coverage to women under 50 or to a woman who is over 50, if she wants to have a mammogram every year; that she would only be allowed coverage for those mammograms every other year rather than on an annual basis. We want to take that away from the act of will, of the government. To suggest that we will deny coverage based on the recommendations of this government task force is not something I think most of us in this country are comfortable with.

We specify very clearly that the Secretary cannot use any recommendations from the USPSTF to deny coverage of any items or services. We also include in the amendment broad protections to prevent, again, the bureaucrats, the government from at benefits partnerships, Health and Human Services, from denying care to patients based on the use of comparative effectiveness research.

Finally, we include a provision that ensures that the Secretary of Health and Human Services may not define or classify abortion or abortion services as preventative care or as preventative services.

This amendment is relatively straightforward. It relies, essentially, on the recommendation of practicing doctors, as opposed to the bureaucrats, to the politicians, to those in office. My amendment addresses the concern that there might be miscalculation of the coverage determinations for your health care decisions. What we are doing here, quite simply, is making it transparent, making clear that the preventative services recommended by the professional medical organizations are visible, are transparent. We require the insurance companies to disclose that information that is recommended and, again, recommended by the professionals.

This is a good compromise. It basically keeps the government out, and it keeps the doctors at the front end. It requires the insurance companies to disclose the information to potential enrollees and allows for, again, a transparency that, to this point in time, has been lacking.

It has been suggested by at least one other Member on the floor earlier that my amendment would cost somewhere in the range of $30 billion. I would like to note for the record, we have not yet received a score on this. We fully believe it will be much less than has been suggested. When the statement was made, it was not with a full view of the amendment we have before us and is not consistent with that. I did wish to acknowledge that as we begin the discussion on my amendment.

Mr. ENZI. Mr. President, first, I wish to thank the Senator from Alaska for the tremendous work she has done on this issue and for the dozens of people she has talked to over the last couple days to try to come up with an amendment that would actually solve the problem everybody has been talking about.

I appreciate the Senator from Maryland recognizing this major flaw in the bill, and it is in the bill. The U.S. Preventive Services Task Force is in the bill. That is exactly the group that specified this new policy on mammograms that has upset people all across the country. It upset everybody so much that we have an amendment on the floor. Senator Murray has been working, chipping away slowly at the increase of breast cancer. We recognize it in our State. Particularly with our Alaska Native populations, we see higher levels of breast cancer than we would like. We are trying to reduce that.

But when these recommendations came out several weeks ago from the USPSTF, I will tell you, there was a buzz around my State amongst women about: Well, now what do I do? Where do I go? Do I need to go in for my screening? What should I do?

There is an article that was actually in the news just, I guess, a couple weeks ago, and it cites a comment from a doctor. Her comment was, the new recommendations were confusing patients who usually come in for their annual screenings. She said: My schedulers have called to schedule patients...
to come in for their followup mammogram, and they have been told: Well, I don't have to do that now. This government group says I don't have to do that.

Mr. President and my colleague from Wyoming, maybe some do not. But what about those who are at risk? These are the ones whom I think we are continuing to hear from who say: Please, add some clarity to this.

Mr. ENZI. Mr. President, I know there is a word that pertains to the word "cancer"—it is cancer. If someone has a family history, there are things you need to be aware of. But I think we have to say that about almost anything. You go to the doctor, and you have a test that is abnormal. You go to the doctors, and you are in remission, you would know—not just ladies either—who have had cancer, and they are trying to give some reassurances to them when this terrible word comes up—when they go to the doctor, one of the first things that happens is they weigh in, they take your blood pressure. When you are waiting for a decision on how the blood test you got turned out or whatever it was, that blood pressure goes through the roof. Quite frequently, you cannot leave the doctor's office until you have—you went there for the information, so, of course, you stay for the followup. They will 2 or 3 have to be made. You do not let you leave until they do the blood pressure test again, to make sure it goes down below the critical stage. That is how much impact this has on people.

So I am glad the Senator did something that goes a little bit further, covers a few more things, and makes sure people have access to their doctor, to the tests they need, and not to be relying on some government bureaucracy to say whether they will die or not. It is important, we do not want that to happen.

I think the Senator's amendment allows patients to get the preventive benefits and stops government bureaucrats and outside experts from ever blocking patients' access to those types of services.

I appreciate the Senator from Maryland who put an amendment. I do not think it meets that standard. They still rely on government experts called the U.S. Preventive Services Task Force to decide what preventive benefits should be covered under private health insurance. This is the same Preventive Services Task Force that made this decision that women under the age of 50 who should not receive annual mammograms.

In fact, I think I even remember in there that they were not necessarily recommending self-examination. Most people I know who are very young discovered it with self-examination. I certainly would not want them to quit doing that because there is a recommendation from somebody who does not understand them or their body.

Patients do want to receive preventive screenings. Sometimes they are a little reluctant to do it because nobody wants the possibility of hearing that word given to them. The American Cancer Society should be able to get screened for high blood pressure and diabetes when a doctor recommends they get these tests. I think the Senator and I agree they should be able to get colonoscopies, prostate exams, and mammograms, so they can prevent deadly cancers from progressing to the point where they are no longer curable. Many of these diseases are preventable or curable or can be put into remission if they are discovered early enough. But they have received a C grade for these screenings to a C.

That sparked the political firestorm, as many women became confused about what services they could get and when they could get them. The health care bills before Congress further confused the issue because they rely heavily on the recommendations of the task force. That is what is in the bill. The underlying Reid bill says—and the Mikulski amendment restates—that all health plans must cover preventive services that receive an A or B grade from the task force. Let's see, we just said that, and it is a C grade.

Because breast cancer screenings for women under the age of 50 are no longer classified by the task force as an A or B, plans would not have to cover those services. So Senator MIKULSKI drafted an amendment to try to fix this problem, but I think it confuses the matter some more.

I say to the Senator, I appreciate the effort you have gone to, to try to clarify that and expand it to some other areas—and to not add another layer of bureaucracy—by saying that all services and screenings must be covered by health plans.

However, the previous amendment does not have any language that are specifically for women or prevention.

Ms. MURKOWSKI. If I may comment on the Senator's last statement, this is very important for people to understand. There has been much said about the Mikulski amendment and what it does. However, the previous amendment does not have any language that are specifically for women or prevention.

As most Americans know, last month the U.S. Preventive Services Task Force revised the recommendations for screening for breast cancer, advising women between the ages of 40 and 49 against receiving routine mammograms and women ages 50 and over to receive a mammogram just once every other year. The U.S. Preventive Services Task Force lowered its grade for these screenings to a C.

That said, the policy of firestorm, as many women became confused about what services they could get and when they could get them. The health care bills before Congress further confused the issue because they rely heavily on the recommendations of the task force. That is what is in the bill. The underlying Reid bill says—and the Mikulski amendment restates—that all health plans must cover preventive services that receive an A or B grade from the task force. Let's see, we just said that was a C grade.

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However, the previous amendment does not have any language that are specifically for women or prevention.
Mr. ENZI. Mr. President, as I said before, the amendment I will offer and consider how it allows for truly that kind of openness, that kind of transparency, and gives individuals the freedom of choice in their health care that I think we all want.

With that, I thank my colleague from Wyoming, and I yield the floor.

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

The Senator from Maine is recognized.

Mr. WHITEHOUSE. I thank the Presiding Officer. I am delighted to be on the floor, along with the distinguished Senator from Maine, and the distinguished Senator from Michigan, who has worked so hard on these issues.
I am sure I am not going to be the only person to say this, but I would like to respond briefly to the colloquy that just took place between the Senator from Wyoming and the Senator from Alaska because, as I understand it, their amendment was written with a purpose for preventive services that are in the A and B category as a floor, not a ceiling, at a minimum, and it instructs the Health Resources and Services Administration to provide recommendations and guidelines for comprehensive women’s preventive care and screenings.

Once that is done, then all plans would be required to be totally apart from the A or the B.

In terms of the Health Resources and Services Administration being an entity that wants to get between you and your doctor, these are actually scientists, not bureaucrats. It is an independent panel.

I think it comes with some irony to hear the concern expressed on the other side of the aisle repeatedly about bureaucrats coming between Americans and their doctors and telling them what care they can and cannot have. That has been the experience in Rhode Island when I took that back to New York, his insurance company bureaucratic headache for the doctor. The private insurance industry is standing between you and the care you need.

I have not once—not once since I have been here—heard anybody on the other side of the aisle express any concern about the bureaucrat between you and your doctor as long as it is an insurance company bureaucrat. It seems to me they actually approve of bureaucrats getting between you and your doctor as long as it is a bureaucrat who is an insurance company bureaucrat who has a profit motive to deny you health care. Then it is OK. Then they don’t complain. But when it is independent scientists working hard to generate the best science that can be done so that people get the best information to make decisions, then suddenly we hear only about bureaucrats.

I think the people listening to this should have that history in mind as they evaluate this claim that we are trying to put bureaucrats between Americans and their doctors. By stripping away from the insurance company, this bill does more to relieve that problem than any other piece of legislation I can think of.

I yield to the distinguished Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. I thank my colleague from Rhode Island because I couldn’t agree more with what he just said. In terms of who is standing between, in this case, a woman and her doctor or any patient and their doctor, Right now, I assume the Senator would agree with me that the first person, unfortunately, the doctor may have to call is the insurance company to somebody, to see what it is going to cost, is it covered. Right now, we know that half the women in this country, in fact, post-pone, delay getting the preventive care they need because they can’t afford it.

So the distinguished Senator from Maryland is all about making sure women can get the preventive care we need, whether it is the mammogram, whether it is the cervical cancer screenings, whether it is focused on pregnancy.

Would the Senator from Rhode Island agree that right now in the marketplace, I understand that about 60 percent of the insurance companies in the individual market don’t cover maternity care?

They don’t cover prenatal care. They don’t cover maternity care, labor and delivery, and health care through the first year of a child’s life. That is standing between a woman, her child, and her doctor. That is the ultimate standing between a woman and her doctor, since they were not going to cover that.

I think one of the most important things we are doing in this legislation is to ensure something as basic as maternity care. When we are 29th in the world in the number of babies that make it through the first year of life, that live through the first year of life, that is something we should all be extremely outraged about, concerned about.

This legislation is about expanding health care coverage, preventive care, making sure babies and moms can get prenatal care, that babies have every chance in the world to make it through the first year of life because we have adequate care there. Yet the ultimate standing between a woman and her doctor is the insurance company saying: We don’t think maternity coverage is basic care.

Mr. WHITEHOUSE. If the Senator will yield.

Ms. STABENOW. Yes.

Mr. WHITEHOUSE. Is that the business model of the private health insurance industry now. They want to cherry-pick out any body who might be sick, and that is why we have the pre-existing condition exclusion.

When they have a big army of insurance company officials whose job it is to deny care. I went to the Cranston, RI, community health center a few months ago. It is a small community health center providing health care in the Cranston, RI, area. It doesn’t have a great big budget. I asked them how difficult it is to deal with the insurance companies in order to get approval and get claims paid. They said: Well, Senator, 50 percent of our personnel are engaged not in providing health care but in fighting with the insurance industry to get permission for care and to get claims paid.

Ms. STABENOW. Will the Senator respond to that to me? That is astounding. He said 50 percent?

Mr. WHITEHOUSE. Yes. Half of the staff of the community health center was dedicated to fighting with the insurance industry, and the other half was actually providing the health care.

In addition, they had to have a contract for experts, consultants, to help fight against the insurance industry.

That was another $200,000—$200,000 for a little community health center, plus half of their staff.

What we have seen in the past 8 years is that the administrative expense of the insurance industry has doubled. That is what they are doing. It is like an arms race. They put on more people to try to prevent you from getting care because it saves them money when they do. They have a profit motive to deny people.

In the case of a member of my family whom they tried to deny, he had the fortitude to fight back and eventually they caved. But for every person like him who fights and gets the coverage they paid for and are entitled to, some will be too ill, too frightened, too old, too weak, too confused, or some simply don’t have the resources, when they are burdened with a terrible diagnosis like that, to fight on two fronts. So they give up and the insurance company takes their money.

It is systematized. Not once have I heard anybody on the other side of the aisle in the Senate complain about that. It is a scandal across this country. It is the way they do business. I don’t think there is a person on the Senate floor who hasn’t heard a story of a friend or a loved one or somebody they know and care about who has been through that process. It is not hypothetical. It is happening now, and it is happening to all of us. But it is only when it comes to your family that suddenly this concern is raised, this “oh my gosh, you are going to get bureaucrats.” But they happen to have no
profit motive. They will work for the government and will be trying to do the right thing and be experts. But suddenly it is no good.

Ms. STABENOW. As the Senator has said eloquently, we have all had situations where we have gone into our insurance industry. Everybody listening and everybody involved in the Senate family has certainly had that happen to us. I have found it very interesting; every Tuesday morning we invite people from Michigan into this town, to come by and we do something called “Good Morning, Michigan.”

I'm finally excited. I am 65 and now I can choose my own doctor because I am going to be on Medicare.

Medicare is a single-payer, government-run health care system. I could not get my mother's Medicare card away from her if I had to wrestle her to the ground because, in fact, it has worked. It is focused on providing health care. That is their mission.

One of the things I think is indicative of the whole for-profit health care system—by the way, we are the only country in the world with a for-profit health care system—is when they talk as an industry, they talk about the “medical loss ratio.” The medical loss ratio is how much they have to pay out on your health care. So the larger the risk pool, the better. It is, to me, a very big red flag, if they have to pay out on your insurance company, calls it a “medical loss” ratio. They have the largest risk pool, as we have in our families, it is different if there is a car accident or if your home is on fire. We understand you don't want to pay out for a car accident or for a home fire. But in this case, we have an institution set up, through which most of us—we have over 82 percent of us in the private for-profit insurance market through our employers. We are in a system where the provider, the insurance company, calls it a “medical loss” if they have to pay out on your insurance. The provider, who is something that, to me, sends a very big red flag, if they are trying to keep their medical loss ratio down.

We have in this legislation been doing things to keep that up. We want them to be paying out for most of the dollars paid on a premium in health care so the people are getting the health care they are paying for. That is what this legislation is about all about. But as my friend from Rhode Island has indicated, point by point, when we look at every amendment in the Finance Committee—I would say virtually every amendment from our colleagues on the Republican side—and when we look at the amendments so far on the floor of the Senate, the first two being offered are about protecting the for-profit insurance companies, making sure excessive payments that are currently going out for for-profit companies under Medicare continue; making sure we are protecting the industry's ability to decide what care you need, when you need it, and so on, but the insurance company's ability to decide what they will pay for, what is covered, when you will get it—and, by the way, if you get too sick, they will find a technicality and they will drop you.

All of those things we are addressing are to protect patients, protect taxpayers, protect providers, those other interests. Would the Senator not agree?

Mr. WHITEHOUSE. I do.

Ms. STABENOW. The sign behind the Senator is right. It is about saving lives, money, and Medicare.

Mr. WHITEHOUSE. As the Senator noted, there is an astonishing similarity between the interests of the private health insurance industry and the arguments made by our friends on the other side on the floor. It is amazing. They are identical, virtually, to one another. I have yet to hear an argument about health care coming from the other side of the aisle that does not reflect the interests and the welfare of the private insurance industry, about which for years I never heard them complain while they were denying care.

We have another example beyond Medicare. I am struck that today is the first day since the President's speech in which he announced another 30,000 troops will be going to Afghanistan in addition to the ones there. All of us in the Senate and in America are proud of our soldiers. We wish them well. Those of us who have visited Afghanistan know how challenging it is and how difficult it is to be away from one's family. There can be no doubt in our minds that we want the best for our men and women in the service. Everyone agrees we want the best for them. Our friends on the other side also want the best for them.

When we give them health care, what do we give them that we think is the best? We give them government health care through TRICARE and through the Veterans Administration. I have not heard one complaint about that, about stripping our veterans out of the Veterans' Administration and letting them go to the tender mercies of the private health insurance industry because when there is not an issue that involves the essential interests of the private health insurance industry, then they will do the right thing and recognize that is best for our service men and women. That is best for our veterans and, of course, we all support right that. But we believe the arguments we are hearing today.

Ms. STABENOW. I totally agree with the Senator. I thank him for his comments. What I find even more perplexing is what we have on the floor is not a single-payer system, even though some of us would support that. It is not. It is, in fact, building on the private system but creating more accountability. We are not saying there would not be a private insurance industry. What we are doing is saying that every individual who cannot find affordable insurance today should be able to pool together in a larger risk pool. That has been, in fact, a Republican and Democratic idea going back years.

We are saying if they want to be able to ask us to cover these folks, we are saying to the insurance companies they have to stop the insurance abuses. Many of them have been buying up companies, buying them a full premium, dropping on some technicality. We want to make sure that women aren't dropped in the midst of having a baby. We want to know that if somebody pays a premium every month, and then somebody gets sick, that they don't get dropped on some technicality. We want to make sure that women aren't dropped twice a year. We want to be able to say this in many cases is happening today. Sometimes there is less coverage. We want to make sure that maternity care is considered basic, that women's health is considered a basic part of a health insurance policy. We are not saying we are eliminating the private sector. We are not going to the VA model or even the Medicare model.

This is reasonable, modest, and should be widely supported on a bipartisan basis. These ideas have come from both Democrats and Republicans over the years, and yet we still get arguments that are wholly and completely protecting the interests of an industry that we are, in fact, trying to engage and provide affordable health care insurance.

Mr. BAUCUS. Mr. President, who has the floor? We are all talking.

The PRESIDING OFFICER. The Senator from Montana is recognized. A colloquy was going on and it was terrific.

Mr. BAUCUS. I ask my colleagues, is it not true that basically in America, although all of America spends about $2.5 trillion on health care, basically it is 50/50. It is 41 or 42 percent public and about 60 percent private. We in America have roughly a 50-50 system today; is that right?

Ms. STABENOW. I say to our colleagues that I believe that is the case. In my State, we have 60 percent in the private market through employers.

Mr. BAUCUS. This legislation before us basically retains the current division. What we are doing is coming up with uniquely American ideas. We are not Great Britain, France, or Canada. We are roughly 50-50—a little more private in fact. In 2007, it was 46 percent private and 54 percent public. Roughly, that is where we are. It might change ever so slightly. But we are not those other countries, we are America.
This legislation before us maintains that philosophy; is that correct?

Ms. STABENOW. Absolutely. In fact, I think it invites the private sector to participate in a new marketplace.

Mr. WHITEHOUSE. If I may interject—this is a relatively familiar American principle to put public and private agencies side by side in competition, in fair competition, and let the best for the consumer win. We see it in public universities. Many of us have public universities that we are very proud of. They compete with private universities. I think every one of us has a public university in our State, and it is a model that works very well in education. Many of us—unfortunately not in Rhode Island—have public authorities that compete with the private power industry.

In fact, some of the most ardent opponents of a public option go home and buy their electricity from a public electric company or a public power authority. We see it in workers compensation insurance. A lot of health care is delivered through workers compensation insurance.

Mr. BAUCUS. But isn’t that a pretty good basket to put too many eggs in one basket? Doesn’t each keep the others on their toes a little bit?

Mr. WHITEHOUSE. I think it is the oldest principle of competition, as the distinguished chairman of the Finance Committee pointed out.

Mr. BAUCUS. Doesn’t this legislation provide for more competition than currently exists?

Mr. WHITEHOUSE. I think it does.

Mr. BAUCUS. For example, with exchanges, with health insurance market reform and with the ratings reform.

Mr. WHITEHOUSE. All of those, and a public option. All of that adds to a better environment. One of the interesting things about this is you only have one market. America is founded on market principles. We all believe in market principles. One of the things about the market is that people will cheat on it if there are not rules around the market. If you don’t make sure that the bread is good, honest, healthy bread, some rascal will come and will sell cheap, lousy, contaminated bread in the market. You have to have discipline and walls to protect the integrity of the market.

The health insurance market has lacked. That is overdue. I think it will enliven the market in health insurance and animate the market principle.

Mr. BAUCUS. I ask my colleagues, is there anything in this legislation which will interfere with the doctor-patient relationship; that is, to date people choose their own doctors, whichever doctor they want. They can, by and large, go to the hospital they want, although the doctor may send them to another hospital. Is there anything in this legislation that diminishes that freedom of choice patients would have to choose their doctor?

Mr. WHITEHOUSE. Nothing.

Ms. STABENOW. If I may add, I think one of the most telling ways to approach that is the fact that the American Medical Association, the physicians in this country, support this legislation. They are the last ones who would support putting somebody—somebody else, I should say, because I believe we have insurance company bureaucrats frequently between our doctors and patients—but they would not be supporting us if it were doing what we have been hearing it is doing.

Mr. BAUCUS. What about the procedures doctors might want to choose for their patients? Is there anything in this legislation which interferes with the decision a physician might make as to which procedure to prescribe, in consultation with his or her patient?

Ms. STABENOW. As a member of the Finance Committee with the distinguished chairman, we have heard nothing that would in any way interfere with procedures. In fact, I believe through the fact we are making insurance more affordable, we are going to make more procedures available because more people will be able to afford to get the care they need.

Mr. WHITEHOUSE. The American Academy of Family Physicians and the American Nurses Association support this legislation because they know that instead of interfering between the doctor and the patient, we are actually lifting out the interference that presently exists at the hands of the private insurance for-profit industry between the patient and the doctor. They want to see this, and that is one of the important reasons.

Another important reason, something the distinguished chairman of the Finance Committee is very responsible for, beginning all the way back at his point of view, the initiative of the Finance Committee, under his leadership, had the “prepare to launch” full-day effort that was the pilot projects, physician-hospital organizations and other similar efforts in this country, all the providers, nurses, doctors, and so on, supporting what we are doing.

Mr. BAUCUS. What about the procedures doctors might want to choose for their patients?

Ms. STABENOW. If I may add, I think the chairman and I thank the chairman for putting in language on the Keystone initiative in the bill—in this bill, we are, in fact, expanding what has been learned about saving lives and saving money by focusing on cutting down on infections in the intensive care units, by focusing on surgical procedures, things that actually will save dollars, don’t cost a lot, and save lives. But they involve thinking a little differently, working a little bit differently as a team. Our plastic institute. It has been written up by the health care writer Dr. Atul Gawande in the New Yorker magazine. What the information from Senator STABENOW’s home State of Michigan shows is that lives have increased by $150 million by better procedures to prevent hospital-acquired infections.

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Mr. BAUCUS. What about the procedures doctors might want to choose for their patients?
As we look at this bill, and as people who have been watching this debate have seen, this legislation saves lives, saves money, and saves medicine. We can vouch for that through the findings of the Congressional Budget Office. But the Congressional Budget Office has been very conservative in its scoring.

Mr. BAUCUS. Very.

Mr. WHITEHOUSE. There is a letter the CBO wrote to Senator CONRAD. There is testimony and a colloquy he engaged in with Senator DODD in the Budget Committee that makes clear that beyond the savings that are clear from this legislation, there is a promise of immense further savings. What he said is: Changes in government policy—

Such as these—
have the potential to yield large reductions in both health care expenditures and Federal health care spending without harming health. Moreover, many experts agree on some general directions in which the government's health policy should move.

The chairman of the Finance Committee has developed those general directions through those hearings and it is now in the legislation. But the conclusion he reaches is:

The specific changes that might ultimately be seen today cannot be foreseen today and could be developed only over time through experimentation and learning.

The MIT report that came out the other day, Professor Gerber, Dr. Gerber said the toolbox to achieve these savings—through experimentation and learning is in this bill. I think his phrase was everything you could ask for in this bill.

As the distinguished chairman of the Finance Committee knows better than I do, there are big numbers at stake here. If you look at what President Obama's Council on Economic Advisers has estimated, there is $700 billion a year—when we talk numbers, we usually multiply by 10 because it is a 10-year period and say when people say there is this much in the bill, it is over 10 years. This is 1 year, $700 billion in waste.

The New England Health Care Institute estimated $550 billion annually in excess costs and waste. The Lewin Group, which has a relatively good opinion around here, and George Bush's former Treasury Secretary, Secretary O'Neill, have estimated it is over $1 trillion a year. So whether it is $700 billion, $550 billion or $1 trillion, even if these tools in the toolbox that we will refine through learning and experimentation achieve only a third, it is $200 billion or $300 billion a year.

Mr. BAUCUS. Right. Some people are worried, perhaps, gee, there they go back there in Congress. They talk about waste—which is good; we want to get rid of waste. But then when they talk about waste, they talk about cutting out the waste, some think: Gee, if they are cutting out the waste, and they are cutting health care reimbursements, gee, won't that hurt health care in America? Won't that reduce quality? If they are cutting so much, $800 billion, $700 billion, $600 billion—that is a lot of money—aren't they going to start cutting quality health care in America?

I see my good friend, the chairman of the HELP Committee on his feet. He may want to join in this discussion as well, adding different points as to why the legislation we are putting together increases quality, does not cut quality, but it increases quality at the same time it saves money. I wonder my colleagues might comment on all of that because it is an extremely important point to drive home. Our legislation improves quality health care.

Mr. DODD. I was going to raise the point, I say to my colleague and chairman of the Finance Committee, that there are a lot of good things about our health care system. We want to start off acknowledging that our providers, doctors do a magnificent, wonderful job. But we say the system is fundamentally broken because it is based on quantity rather than quality.

That is my question. There is a question mark at the end of it. It is my opinion that is what it is. In other words, doctors and hospitals—the system—are rewarded based on how many patients you see, how many hospital beds are filled, how many tests get done, how many screenings are provided along the way. So it is all based on quantity and I think yesterday it deserves being repeated—it isn't just at the Cleveland Clinic or the Mayo Clinic where this happens—that kind of culture that exists at community hospitals and small hospitals all over the country where they have figured out integrated care; that is where doctors and hospitals have figured out how to provide services and reduce costs.

There is a fellow by the name of Don Berwick, a doctor who is an expert on integrated care, and one of the things he said—and I think you said this yesterday it deserves being repeated—it isn't just at the Cleveland Clinic or the Mayo Clinic where this happens—that kind of culture that exists at community hospitals and small hospitals all over the country where they have figured out integrated care; that is where doctors and hospitals have figured out how to provide services and reduce costs.

I have 31 hospitals in my State, and similar to all our colleagues, I have been visiting many of them and talking to people. Manchester Hospital is a very small hospital in Manchester, CT—a community hospital—and they have reduced costs and increased quality because they have figured out, between the provider physicians and the hospital, how to do that. My point is—and your point is—this is happening all across America in many places, and we need to be rewarding that when it occurs.

Mr. BAUCUS. There is no doubt about that. In fact, it is interesting the Senator mentioned his name because not too long ago I asked a question. I said: Why, Dr. Berwick, is it that in some communities they get it and some they do not? His answer was that sometimes there is somebody—maybe it is a hospital or someone who is a pretty dominant player—who kind of starts it out and gets it right, and that is true.

He invited 10 integrated systems to Washington, DC, to kind of talk over what works and what doesn't work.
These are not the big-named institutions; they are the lesser named institutions. In fact, one of them I can probably say is the Billings Clinic, in Billings, MT—not too widely known, but they participated last year—the same process and integration with the doctor, the acute care, and the postacute care. They have significantly cut costs, they have significantly improved the quality, and they are very proud of what they have done.

Mr. BAUCUS. May I offer a specific example from the bill as an illustration of this?

One of the very few areas in which the Congressional Budget Office is prepared to document savings from these quality improvements is in the area of hospital readmissions. The chairman of the Finance Committee worked very hard to get hospital readmission language in his bill. I think we had it in the HELP bill as well. Chairman DODD, the chairman of quality improvements is in the area of compared to document savings from these specific examples from the bill as an illustration of this.

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you can't just say it and not explain how you do it. What we have done in our bill is explain how we do that, how we increase access, how we improve quality for the individual and institutions and simultaneously bring down cost. That is what we spent the last year doing and we achieved exactly what is in these pages that people weigh and pick up all the time. If they would look into them, they would see the kind of achievements we have reached.

These achievements have been recognized by the most important organizations affecting older Americans—AARP and the Commission to Preserve Social Security and Medicare. They have examined this. These are not friends of ours. These are people who objectively analyze what we are doing, and it is their analysis, their conclusion, reached independently, along with many others, that we have been able to reduce these costs, these savings, in this bill and simultaneously increase access and improve quality.

That has been the goal we have all talked about for years. This bill comes as close to achieving the reality of those three missions than has ever been achieved in this Congress, or any Congress for that matter. So when people talk about these cuts in Medicare, they need to be honest enough for people to realize what we have done is to stabilize Medicare, extend its solvency, and guarantee those benefits to people who rely on Medicare. That has all been achieved in this bill.

So when people start with these scare tactics and language to the contrary, listen to those organizations who don't bring any political brief to this, who don't have an R or a D at the end of their names. Their organizations are designed, supported, financed by, and applauded by the very individuals who count on having a solid, sound Medicare for the years of independence, for as many years as possible. It is important. It is essential. It is the key to keeping these moneys from being taken from the programs by organizations that would use them for other purposes. We have attempted for just this purpose. You cannot raid this fund for any other purpose—which is one of the reasons of the actuarial soundness of this program. The CLASS Act assists individuals who need long-term services and supports with such things as: assistance to transportation in-home meals, help with home aid services, professional help getting ready for work, adult day care, and professional personal care. It also saves about $2 billion in Medicaid savings. There are very few provisions which almost instantaneously do that.

Again, these dollars have to remain just for this purpose. You cannot raid this fund for any other purpose—which was a concern legitimately raised by some, that this $75 billion may be used for other purposes. We have attempted to write into this legislation prohibitions to keep these moneys from being offered for any other purpose.

In fact, Senator Gregg, when he offered his amendment, said: I offered an amendment, which was ultimately accepted, that would require the CLASS Act premiums be based on a 75-year actuarial analysis of the program's costs. My amendment ensured that instead of promising more than we can deliver, the program will be fiscally solvent and we won't be passing the buck—or really passing the debt—to future generations. We have attempted to make sure the HELP Committee unanimously accepted this amendment.

Which we did. I hear some of my colleagues say this bill did not have anything to do with helping those of the 161 Republican amendments I took during committee markup—this was one of the amendments, Senator Gregg's amendment, which we accepted unanimously. My colleague from Utah was of course a member of the committee. He diligently and forcefully toolkit every amendment that was offered and I know remember as we adopted one of his amendments dealing with biologics in the committee that Senator Kennedy strongly supported in conjunction with Senator Hatch. But this CLASS Act is a unique and creative idea. We thank our colleague from Massachusetts, no longer with us, for coming up with and conceptualizing this idea that impacts not only the individuals who contribute into the fund, the money, contributing to a fund, could eventually draw down to provide these benefits should they become disabled. Individuals often want to continue working and being self-sufficient without getting into Medicaid, which limits your income, restrains you entirely.

Here is a totally privately funded program, no public money, just what you are willing to contribute over a period of years to protect against that eventuality that you might become disabled, so you can continue to function.

I have one case here, Sara Baker, a 33-year-old woman in my home State of Connecticut living in Norwalk. Two years ago Sara's mother, who was only 57 years old and the backbone of the family, suffered a massive stroke. The stroke left the right side of her body completely paralyzed. She lost 100 percent of her speech. Sara recalls that fateful day when she got the call. I will quote her:

I was living out west in Arizona—working, dating—living and loving my life. Then... I got the phone call. . . . In seconds, literally, my entire world fell apart. I swear I could still feel that feeling through my whole body when I think about it. So there I was in a state of complete and total lunacy, getting on a plane with one suitcase—home to Connecticut. Guess what? She lived!

Sara's mother was transferred to a rehab hospital. Sara went to the hospital every single day for 2 months to be at her mother's side as she went through therapy. Sara's mother had worked as an RN for 17 years. Her mom and the hospital social worker both agreed that health insurance was "as good as they come."

However, when it comes to long-term care, they don't come as good. Her mother was abruptly discharged from the rehab hospital after 60 days, when her health insurance decided she had made enough "progress."

Sara went 9 months without working, dipped into what savings she had, and then went into debt to provide the long-term services and supports her mother needed.

As she recalled, and I will quote her again:

I made the whole house wheelchair accessible. I became a team of doctors, nurses, aides, and a homemaker. I helped her shower, get dressed, cut food, gave medicine, took her blood pressure... What would have happened if I wasn't there? Basically, one of two things—I could have hired someone to come to the house, all out of pocket of course, or the State could have depleted her assets—her home, savings, everything—and she would have been put in a nursing home funded by Medicaid.

Stories like Sara's are not the exception, unfortunately. They happen every minute of every day, all across our country. They are common in my State
as well as any other State in the Nation. At any moment any one of us or someone we love can become disabled and need long-term services.

We also have an aging population. In my home State of Connecticut, the number of people 65 and older will rise from 589,000 to 1.1 million, making us the fastest growing age group in the State. This is critical of the program. Senator GREGG’s ideas were adopted unanimously in our markup of the bill and provided the actuarial soundness of this proposal for a long 75 years to come. For the useful to him, for offering those amendments which were adopted by every Republican and every Democrat on the committee at the time of our markup last summer.

I see my colleague from Utah, and I have great respect for my friend from Utah. He and I have worked on so many issues together. Either he would get me in trouble politically when we worked on in the Chamber was to establish some Federal support for families such as Sarah’s. As I said earlier, the CLASS Act is getting. It is not intended to cover all the costs of long-term care but it could help many families like Sarah’s. It could pay for assistive devices and equipment. It could pay for personal assistant services—allowing all individuals with disabilities to maintain their independence, and community participation. It could allow individuals to stay in their homes versus having to go to a nursing home. It would reduce the deficit by $54 billion over 10 years. That is a lot of money. Private sector savings would be even more significant. According to the CBO, these measures would reduce the deficit by $1 trillion over 10 years. That is a lot of money.

Mr. Hatch, Mr. President, I thank my colleague. There is no question he is a great Senator. I have always enjoyed working with him and we have done an awful lot together. I want to compliment Senator WHITTHOUSE too, a terrific human being and a great addition to this Senator. He is a lot of respect for him. He gives me heartburn from time to time, as does Senator DODD. On the other hand, they are great people and very sincere. Our chairmen of the committee, Max BAUER, and wonderful thing to do the best he could under the circumstances. I applaud him for it. Senator STABENOW from Michigan and I have not seen eye to eye on a lot of things, but we always enjoy being around each other.

This is a great place, there is no question about it. We have great people here. But that doesn’t make us any less unhappy about what we consider to be an awful bill.

So while this proposal is not going to solve every problem, it is a very creative, innovative idea that can make a difference in the lives of millions of our fellow citizens, not only today but for years to come.

I again thank Senator Kennedy and his remarkable staff who did such a wonderful job on this as well, and I thank him through he is critical of the program. Senator GREGG’s ideas were adopted unanimously in our markup of the bill and provided the actuarial soundness of this proposal for a long 75 years to come. For the useful to him, for offering those amendments which were adopted by every Republican and every Democrat on the committee at the time of our markup last summer.

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So while this proposal is not going to solve every problem, it is a very creative, innovative idea that does not involve a nickel of public money, not a nickel. It is all voluntary, depends upon the individual willing to make that contribution, to provide that level of assistance. Lord forbid they should end up in a situation where they find themselves disabled and need some long-term services to allow them to survive and be part of their community life, including going back to work, without impoverishing themselves. It is all voluntary, depends upon the individual willing to make that contribution, to provide that level of assistance. Lord forbid they should end up in a situation where they find themselves disabled and need some long-term services to allow them to survive and be part of their community life, including going back to work, without impoverishing themselves.

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brought to get the defense costs which then only ranged from $50,000 to $200,000, depending on the jurisdiction. If a lawyer can get a number of those cases they can make a pretty good living by bringing those cases just to get the defense costs which of course adds to all the costs of health care. There is no use kidding about it.

Furthermore, Senator DURBIN, the distinguished Senator from Illinois, cited the same CBO letter in order to claim that the tort reform measures supported by many on my side of the aisle would cause more people to die. Give me a break.

I can only assume he is referring to the one paragraph in the CBO letter that addresses the effect of tort reform on health outcomes. In that single paragraph the CBO referred to three studies. One of these studies indicated that a reduction in malpractice lawsuits would lead to an increase in mortality rates. The other two studies cited by the CBO found that there would be no effects on health outcomes and no negative effects could be expected. So, let's be clear, the CBO did not reach a conclusion. These studies were cited only to show that there is disagreement in this area and, once again, the majority of the studies cited said there would be no negative effects on health outcomes. Apparently, omitting data and studies that disagree with your conclusions of the three.

In his speech earlier today, the distinguished Senator from Illinois also discounted the prominence of defensive medicine in our health care system, saying only that “some doctors” perform unnecessary and inappropriate procedures in order to avoid lawsuits. Once again, the facts would contradict this generalization. A number of studies demonstrate this. For example, a 2005 study of 800 Pennsylvania physicians—where I used to practice law—in high-risk specialties found that 93 percent of these physicians had practiced some form of defensive medicine. That was published in the Journal of the American Medical Association, June 1, 2005.

In addition, a 2002 nationwide survey of 300 physicians—this is the Harris Interactive “Fear of Litigation Study”—found that 79 percent of physicians ordered more tests than are necessary. Think about that. If 79 percent are ordering more tests than are necessary, you can imagine the multbillions of dollars in unnecessary defensive medicine that comes from that. But that is not the end of that “Fear of Litigation Study.” Seventy-four percent of physicians referred patients to specialists who they knew they didn’t need. Think of the cost, the billions of dollars in cost. Fifty-two percent of physicians suggested unnecessary invasive procedures. The word “invasive” is an important word. Fifty-two percent. Why? Because they are trying to protect themselves by making sure that everything could possibly be done. Forty-one percent of physicians prescribed unnecessary medications. This is a nationwide survey of physicians.

The costs associated with defensive medicine are real—I would say unnecessary defensive medicine because I believe there are some defensive medicine approaches that want the doctors to do but not to the extent of these doctors ordering more tests than are necessary, ordering more specialists than are necessary, suggesting unnecessary invasive procedures, unnecessary medications. This is the medical profession itself that admits this.

In another study Pricewaterhouse found that defensive medicine accounts for approximately $210 billion every year or 10 percent of the total U.S. health care cost. Here are some more facts from that study. Of the $2.2 trillion spent every year on health care in the United States, as much as $1.2 trillion can be attributed to wasteful spending—$1.2 trillion of $2.2 trillion. Yet, the Democrats want to dismantle defensive versus necessary defensive medicine. That is being utilized to a significant extent. According to this study, defensive medicine is the largest single area of waste in the health care system. It is on par with inefficient processing and care spent on preventable conditions.

Yet, despite these overwhelming numbers—and I know some Democrats will say that is Pricewaterhouse and they must have been doing it at the expense of someone who had an interest, Pricewaterhouse and other accounting firms generally try to get it right. They got it right here. Those of us who were in that business can attest to it. Yet, despite these overwhelming numbers on the other side, some critics have opted to overlook them and instead relate horrific stories associated with doctors’ malpractice, apparently trying to imply that Republicans simply don’t care about these truly tragic occurrences. However, nothing could be further from the truth. In fact, in all the proposals that have been offered during this debate, there has not been a single suggestion to prevent plaintiffs from obtaining the compensation they may have incurred. Rather, there was not one suggestion that they should. Instead, we have sought to impose some limits on the noneconomic damages. All economic damages damages awarded for actual loss, past, present, and future—are fine, fair game. We've sought only impose some limits on the noneconomic damages in order to define the playing field, encourage settlement, and introduce some level of predictability to the system.

It is no secret that personal injury lawyers—are prolific political contributors to those politicians who fight against tort reform. With a Democratic majority and a Democrat in the White House, their lobbying efforts during this Congress have reached unprecedented levels. Given this reality, it is obvious why trial lawyers have not been asked to give up anything in the current health care legislation.

The very purpose of this health care bill will be asking the American people to pay higher health care premiums, for seniors to give up Medicare Advantage, which 25 percent of them have enlisted in, for businesses to pay higher taxes, for medical device companies to pay more just to bring a device to the market that may save lives or make lives more worth living. The only group that has not been asked to sacrifice or change the way they do business happens to be the medical liability personal injury lawyers.

I would hope we would focus our efforts more on helping the American people than on preserving a fund-raising stream for politicians. Sadly, that doesn't appear to be so much as happening in the current debate.

As I said, there are some very honest and decent attorneys out there who bring cases that are legitimate where there should be high rewards. But the numbers of these are less than legitimate and the resulting costs are costing every American citizen an arm and a leg. It is something we ought to resolve. We ought to resolve it in a way that takes care of those who truly have injuries and get rid of these frivolous cases driving up the cost for every American.

Not too long ago, I talked to one of the leading heart specialists in Washington. He acknowledged, we all order a lot of tests and so forth that we don’t need, that we know we don’t need. But we do so that the history we have of the patient shows we did everything possible to rule out everything that possibly could occur, even though we know we really don’t need. To be honest, under the current system of lawsuits, I don’t blame them. They are trying to protect themselves.

We should also discuss the shortage of doctors we have going into high-risk specialties. We have areas in this country where you can’t get obstetricians and gynecologists to the people. Law schools will tell you, at least the ones I know, that there aren’t that many young people going into obstetrics and gynecology today because they may not make as much money and the high cost of medical liability insurance is so high that they really can’t afford to do it. And, of course, they don’t want to get sued.

So much for that. I love my distinguished friend from Illinois, and he knows it. I care for him. But let me tell you, I think he knows better. He knows that I know better. I would be the first to come to bat for somebody who was truly injured because of the negligence of a physician. I don’t have any problem with that at all.

I just thought I would make a few comments about this but, again, say
that I understand some of the excesses that go on on the floor. But that was an excess this morning, even though I know my dear friend is sincere and dedicated and one of the better lawyers in this body. Having said that, I will end on that particular subject.

Let me once again talk to a few minutes to talk about the Medicare provisions in this Democratic Party health care bill.

Throughout the health care debate, we have heard the President plead not to "mess" with Medicare. Unfortunately, that is not the case with the bill before the Senate. To be clear, the Reid bill reduces Medicare by $145 billion to fund a new government program. Unfortunately, seniors and the disabled in the United States are the ones who suffer the consequences as a result of these reductions. Everyone knows Medicare is extremely important to 43 million seniors and disabled Americans covered by the Medicare Program.

Throughout my Senate service, I have fought to preserve and protect Medicare for both beneficiaries and providers. Medicare is already in trouble today. The program faces tremendous changes in the very near future. The Medicare trust fund will be insolvent by 2017, and the program has more than $37 trillion in unfunded liabilities. This is going to be saddled onto our children and grandchildren.

The Reid bill will make the situation much worse. Why is that the case? Again, the Reid bill cuts Medicare to fund the creation of a new government entitlement program. More specifically, the Reid bill will cut nearly $125 billion from home health care agencies, and close to $5 billion from hospice care centers. These cuts will threaten beneficiary access to care as Medicare providers find it more and more challenging to provide health services to Medicare patients. Many doctors are not taking Medicare patients now because of low reimbursement rates.

Let me stress to my colleagues that cutting Medicare to pay for a new government entitlement program is irresponsible. Any reductions to Medicare should be used to preserve the program, not to create a new government bureaucracy.

As I just said, the President has consistently pledged: We are not going to mess with Medicare. Once again, this is another example of a straightforward pledge that has been broken over the last 11 months. Maybe you cannot blame the President because he is not sitting in this body. The body is breaking it.

This bill strips more than $120 billion out of Medicare Advantage. The Medicare+Choice program that currently covers 10.6 million seniors or almost one out of four seniors in the Medicare Program. According to the Congressional Budget Office, under this bill the value of the so-called "additional benefits," such as vision care and dental care, will decline from $135 to $42 by 2019. That is a reduction of more than 70 percent in benefits. You heard me right: 70 percent.

During the Finance Committee’s consideration of health care reform, I offered an amendment to protect these benefits for our seniors, many of whom are low-income Americans and reside in rural States and rural areas. However, the majority party really did not support this important amendment. The majority chose to skirt the President’s pledge about no reduction in Medicare benefits for our seniors by characterizing the benefits being lost—vision care, dental care, and reduced hospital deductibles—as "extra benefits."

Let me make the point as clearly as I can. When we promise American seniors we will not reduce their benefits, let’s be honest about that promise. So when we say Medicare Advantage is not part of Medicare, or not. It is that simple. Under this bill, if you are a senior who enjoys Medicare Advantage, the unfortunate answer is, no, they are not going to protect your benefits.

All day today, we had Members on the other side of the aisle claim that Medicare Advantage is not part of Medicare. This is absolutely—I have to tell you, it is absolutely unbelievable. I would invite every Member making this claim to turn to page 50 of the “2010 Medicare and You Handbook.” It says:

A Medicare Advantage is another health coverage choice you may have—

Get these words—

as part of Medicare.

Let me repeat that:

A Medicare Advantage is another health coverage choice you may have as part of Medicare.

Hey, that is the Medicare “2010 Medicare and You Handbook.” Who is kidding whom about it not being part of Medicare?

So the bottom line is simple: If you are cutting Medicare Advantage benefits, you are cutting Medicare.

I also heard the distinguished Senator from Connecticut this morning mention that the bureaucracy-controlled Medicare Commission will not cut benefits in Part A and Part B. Well, once again, my friends on the other side are only telling you half the story. So much for transparency. On page 1,005 of this bill, it states in plain English:

Include recommendations to reduce Medicare payments under C and D.

I am just waiting for Members on the other side of the aisle to come down and now claim that Part D is also not a part of Medicare. We all know it is.

It is also important to note that the Director of the bipartisan Congressional Budget Office has told us in clear terms that this unfettered authority given to the Medicare Commission would result in higher premiums.

It is important details such as these that the majority does not want us to discuss and debate in full view of the American people. They call it slow-walking. They call it obstructionism. Making sure we take enough time to discuss a 2,074-page bill that will affect every American business is the sacred duty of every Senator in this Chamber. We will take as long as it takes to fully discuss this bill, and you can talk for a month about various parts of this bill that are outrageous and some that are not good, too, in all fairness—not many, however.

I have heard several Members from the other side of the aisle characterize the Medicare Advantage Program as a giveaway to the insurance industry. You know, when you cannot win an argument, you start blaming somebody else. So they want a government insurance company to take the place of the insurance industry. Well, maybe that is not their insurance company. They want it to compete with the insurance industry. But how do you compete with a government-sponsored entity? And there are comments that the so-called government plan will cost more than the current private insurance plans. They are so criticizing. I am not happy with the insurance industry either, but, by gosh, let’s be fair.

Let me give everyone watching at home a little history lesson on the creation of Medicare Advantage. I served as a member of the House-Senate conference committee which wrote the Medicare Modernization Act of 2003. The distinguished Senator from Montana would agree with me, it was months of hard, slogging work every day to try to come up with the Medicare Modernization Act of 2003. Among other things, this law created the Medicare Advantage Program. It gives people vision care, dental care, et cetera.

When conference committee members were negotiating the conference report back then, in 2003, several of us insisted that the Medicare Advantage Program was necessary in order to provide health care coverage choices to Medicare beneficiaries. At that time, there were many parts of the country where Medicare beneficiaries did not have adequate choices in coverage. In fact, the only choice offered to them was traditional fee-for-service Medicare, a one-size-fits-all, government-run health program.

By creating the Medicare Advantage Program, we were providing beneficiaries with choice in coverage and then empowering them to make their own health care decisions as opposed to the Federal Government making them for them. Today, every Medicare beneficiary may choose from several health plans.

We learned our lessons from Medicare+Choice, which was in effect at the time, and its predecessors. These plans collapsed, especially in rural areas, because Washington decided—
again, government got involved—to set artificially low payment rates. In fact, in my home State of Utah, all of the Medicare+Choice plans eventually ceased operations because they were all operating in the red. You cannot continue to do that. It was really stupid what we were expecting them to do. I fear history could repeat itself if we are not careful.

During the Medicare Modernization Act conference, we fixed the problem. We increased reimbursement rates so all Medicare beneficiaries, regardless of where they lived—be it Fillmore, UT, or New York City—had choice in coverage. Again, we did not want beneficiaries stuck with a one-size-fits-all, Washington-run government plan.

There were both Democrats and Republicans on that committee, by the way, and the leader was, of course, the distinguished Senator from Montana. I admire him for the way he led it, and I admire him for trying to present what was the most untenable case here on the floor during this debate. He is a loyal Democrat. He is doing the best he can, and he deserves a lot of credit for sitting through all those meetings and all of that markup and coming in and sitting day-in and day-out on the floor here.

Today, Medicare Advantage works. Every Medicare beneficiary has access to a Medicare Advantage plan, if they so choose, and close to 90 percent of Medicare beneficiaries participating in the program are satisfied with their service. That is to our senior citizens. Very many of us are already operating in the red. You cannot continue to do that. It was really stupid what we were expecting them to do. I fear history could repeat itself if we are not careful.

In States such as Utah, Idaho, Colorado, New Mexico—just to mention some Western States—Wyoming, Montana—you can name every State—rural America was not well served, and we did Medicare Advantage.

Care has been made a difference in the lives of more than 10 million Americans nationwide—almost 11 million Americans. The so-called “extra benefits” I mentioned earlier are being portrayed as gym memberships as opposed to lower premiums, copayments, and deductibles.

To be clear, the Silver Sneakers Program is one that has made a difference in the lives of many seniors because it encourages them to get out of their homes and remain active. It is also a reasonable idea at its best. It has been helpful to those with serious weight issues, and it has been invaluable to women suffering from osteoporosis and joint problems. In fact, I have received several hundred letters telling me how much Medicare Advantage beneficiaries appreciate this program. They benefit from it. Their lives are better. They use health care less. They do not milk the system. They basically have a better chance of living and living in greater health.

Throughout these debates, regardless of where we were, throughout these markups, throughout these hearings that have led us to this point, every health care bill I know of has a prevention and wellness section in the bill that will encourage things such as the Silver Sneakers Program that has benefited senior citizens so much and was not one of the major costs of Medicare Advantage.

Additionally, these beneficiaries receive other services such as coordinated chronic care management, which is important, coordinated chronic care management for seniors; dental coverage—really important for low-income seniors; vision care—can you imagine how important that is to our senior citizens? This program helps these seniors, and it helps them the right way.

Let me read some letters from my constituents. These are real lives being affected by the cuts contemplated in the bill.

Remember, there is almost $500 billion in cuts to Medicare, which goes insolvent by 2017 and has an almost $38 trillion unfunded liability.

Let me read this letter from a constituent from Layton, UT:

I recently received my healthcare updater for 2010. I am in a Med Advantage plan with Blue Cross/Blue Shield. Thanks to the cuts in this program by Medicare, my monthly premium has risen by 49% and my office visit co-pay has increased 150%. Senator Hark, I am on a fixed income and this has substantially decreased. We are in our 80s and significantly increased with the coverage subtraction. I have been a Medicare Advantage plan beneficiary since I turned 65 and have eventually been signed into law. We are the body that has in the past and should today be working through these difficult issues to find clear consensus. True bipartisanship is what is needed.

In the past, the Senate has approved many bipartisan health care bills that have eventually been signed into law. I know a lot of them have been mine, along with great colleagues on the other side who deserve the credit as well. The Balanced Budget Act in 1997 included the Hatch-Kennedy SCHIP program. How about the Ryan White Act. I stood right here on the Senate floor and called it the Ryan White bill. His mother was sitting in the audience at the time. How about the Orphan Drug Act? When I found that there were only two or three orphan drugs being developed. These are drugs for population groups of less than 250,000 people. It is clear that the pharmaceutical companies could not afford to do the pharmaceutical work to come up with treatments or cures for orphan conditions. So we put some incentives in there; we put some tax incentives in there. We did some things that were unique. If I recall it correctly, it was about a $1 million bill.

Today, we have decided in essentials substantial increases in the costs of living and cannot afford these increases and are hurt by the decreased coverage. We are writing to you to have you stop the cuts and restore the coverage to Medicare Advantage plans. This is an issue that is very important and very real to us at this point in our lives. Please stop the cuts and restore the coverage to Medicare Advantage plans.

I cannot support any bill that would jeopardize health care coverage for Medicare beneficiaries. I truly believe if this bill before the Senate becomes law, Medicare beneficiaries’ health care coverage could be in serious trouble.

I have been in the Senate for over 30 years—33 to be exact. I pride myself on being bipartisan. I have coauthored many bipartisan health care bills since I first joined the Senate in 1977. Almost everyone in this Chamber wants a health care reform bill to be enacted this year. I don’t know of anybody on either side who would not like to get a health care bill enacted.

On our side, we would like to do it in a bipartisan way, but this bill is certainly not bipartisan. It hasn’t been from the beginning. We want it to be done right. History has shown that to be done right, it needs to be a bipartisan bill that passes the Senate with a minimum of 75 to 80 votes. We did it in 2003 when we considered prescription drug legislation, and I believe we can do it again today if we have the will and if we get rid of the partisanship. I doubt there has ever been a bill of this magnitude affecting so many American lives that has passed this Chamber on an almost—or maybe in a complete—straight party-line vote. The Senate is not the House of Representatives. This body has a different constitutional mandate than the House. We are the deliberative body. We are the body that has in the past and should today be working through these difficult issues to find clear consensus. True bipartisanship is what is needed.
hadn’t been for that little, tiny orphan drug bill. That was a major bill when I was chairman of the Labor and Human Resources Committee. They now call it the Health, Education, Labor, and Pensions Committee.

How about the Americans With Disabilities Act. Tom Harkin stood there, I stood here, and we passed that bill through the Senate. It wasn’t easy. There were people who thought it was too much Federal Government, too much this, too much that. But Senator Harkin and I believed—as did a lot of Democrats and a lot of Republicans, as the final vote showed—that we should take care of persons with disabilities if they would meet certain qualifications.

How about the Hatch-Waxman Act. We passed that. Henry Waxman, a dear friend of mine, one of the most liberal people in all of the House of Representatives and who is currently the very powerful chairman of the Energy and Commerce Committee over there, we got together, put aside our differences, and we came up with Hatch-Waxman which basically almost everybody admits created the modern generic drug industry.

By the way, most people will admit that since Hatch-Waxman was signed, we have saved at least $10 billion to consumers and more today, by the way, every year since 1984.

I could go on and on, but let me just say I have worked hard to try and bring our sides together so we can in a bipartisan way do what is right for the American people.

Let me just tell my colleagues, if the Senate passes this bill in its current form with a razor thin margin of 60 votes, this will become one more example of the arrogance of power being exercised since the Democrats secured a 60-vote majority in the Senate and took over the House and the White House.

There are essentially no checks or balances found in Washington today, just an arrogance of power, with one party ramming through unpopular and devastating proposals such as this, one after another.

Well, let me say there is a better way to handle health care reform. For months I have been pushing for a fiscally responsible and step-by-step proposal that recognizes our current need for spending restraint while starting us on a path to sustainable health care reform. There are several areas of consensus that can form the basis for such a proposal.

One is health care reform efforts so they can take care of persons with disabilities if they would meet certain qualifications.

These include:

- Reforming the health insurance market for every American by making sure no American is denied coverage simply based on a preexisting condition. Some of my colleagues on the other side have tried to blast the insurance industry, saying they are an evil, powerful industry. We need to reform them, no question about it, and we can do it if we work together.

- Protecting the coverage for almost 85 percent of Americans who already have coverage they like by making that coverage more affordable. This means reducing costs by rewarding quality and coordinated care, giving families more information on the cost and choices of their coverage and treatment options, and—I said it earlier—discouraging frivolous lawsuits that have permeated our society and made the lives of a high percentage of our doctors, especially in those very difficult fields of medicine, painful and those fields not very popular to go into today. And, of course, we must promote prevention and wellness measures.

We could give States flexibility to design their own unique approaches to health care reform. Utah is not New York, Colorado is not California, New York is not Utah, and New Jersey is not Colorado. Each State has its own demographics and its own needs and its own problems. Why don’t we get the people who know those States best to States that are successful. I know the legislators closer to the people are going to be very responsive to the people in their respective States. I admit some States might not do very well, but most States are much better than what we will do here with some big albatross of a bill that really does not have bipartisan support.

Actually, in talking about New York, what works in New York will most likely not work in Colorado, let alone Utah. As we move forward on health care reform, it is important to recognize that every State has its own unique mix of demographics. Each State has developed its own institutions to address its challenges, and each has its own successes. We can have 50 State laboratories determining how to do health care in this country in accordance with their own demographics, and we could learn from the States that are successful. We could learn from the States that make mistakes. We could learn from the States that cross-breed ideas. We could make insurance so that it crosses State lines.

If we pass this bill, we could do it. But there is no need to do that today.

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my knowledge, had even been asked to help, and it is a tremendously partisan bill—both of which are tremendously costly too.

Then the distinguished Senator from Montana tried to come up with a bill that would be bipartisan. He proposed it in the Finance Committee, but in the end, even with the Gang of 6—and I was in the original Gang of 7, but I couldn't stay because I knew what the bottom bill was going to be, and I knew I could not support it voluntarily, not because I wanted to cause any problems but because I didn't want to cause any problems. I found myself coming out of those meetings and decrying some of the ideas that were being pushed in those meetings. I just thought it was the honorable thing to do to absent myself from the Gang of 7. It became a Gang of 6 and then the three Republicans finally concluded that they couldn't support it either.

But I will give the distinguished chairman from Montana a great deal of credit because he sat through all of that. He worked through all of it. He worked through it in the committee, but then it became a partisan exercise in Congress.

Yes, there were a couple of amendments accepted: My gosh, look at that. Then what happened? They went to the majority leader's office in the Senate, and they brought the HELP bill and the bill from the Finance Committee, and they melded this bill, this 2,074-page bill with the help of the White House. Not one Republican I know of had anything to do with it, although I know my dear friend, the distinguished majority leader, did from time to time talk with at least one Republican, but only on, as far as I could see, one or two very important issues in the bill. There are literally thousands of important issues in this bill, not just one or two. There are some that are more important than others, but they are all important.

I am not willing to saddle the American people with this costly, overly expensive, bureaucratic nightmare this bill will be. I hope my colleagues on the other side will listen, and I hope we can start over on a step-by-step approach that takes in the needs of the respective States that is not a one-size-fits-all solution, that both Republicans and Democrats can work on, which will literally follow the principles of federalism and get this done in a way that all of us can be proud of. I don't have any illusions and, thus far, it doesn't look like that will happen. But it should happen. That is the way it should be done. I warn my friends on the other side, if they succeed in passing this bill without bipartisan support—if they get one or two Republicans, I don't consider that bipartisan support. You should at least get 75 to 80 votes on a bill this large, which is one-sixth of the American economy, 17 percent of the American economy. You should have to get 75 to 80 votes minimally. It would even be better if you can get more, as we did with CHIP and other bills. On some we have gotten unanimous votes—on bills that cost money, by the way. Republicans have voted for them, too. Republicans will vote for a good bill even if it costs some money, not just to vote for something costing $2.5 trillion to $3 trillion. I don't think the American people are going to stand for it.

Beware, my friends, of what you are doing. I can tell you right now this isn't going to make that point as clear as I can.

With that, I yield the floor.

The PRESIDING OFFICER (Mr. BENNET). The Senator from Illinois is recognized.

Mr. BURRIS. Mr. President, as a lifelong public servant, I have always believed in the fundamental greatness of this country. I am sure this is a belief shared by every single one of my colleagues to whom I drove us to serve in the first place, just as it has driven generations of Americans to serve in many capacities throughout our history, Democrat or Republican, liberal or conservative, we are united by our underlying faith in the democratic process and the principle of the people we have come here to represent. That is what makes this country great, the belief that together we can make progress. Together, we can shape our own destiny. That is why we gather here on this hallowed floor of the United States Senate, to give voice to their concerns and interests, and the partisan tug of war, the weight of consensus is hard to ignore. Folks stop me on the streets, stop me in hallways outside of my office, talk to me on airplanes; they call, write, e-mail. They come every way possible. The message is always the same: We need real health care reform. They are telling me don't give up and don't back down. That is because the American people overwhelmingly support reform. They need health care reform now—not tomorrow or next year, they need it now.

I urge my colleagues to think of the uninsured people in their own States. Think about that. Who are the ones who are uninsured? These are the folks who need reform the most. We have all heard at least a few of the heartbreaking stories. Sadly, we will never be able to hear them all because there are so many. So I ask to listen and to take a stand on their behalf. It is time to bring comprehensive health care reform to every State in the Union, because in my home State of Illinois, 15 percent of the population is uninsured. In the most advanced country on earth, this is simply unacceptable. We need to dramatically expand access to quality, affordable health care. But it is not just a blue States issue, it is an American issue. That is why the health care bill of us. In fact, as we look across the map, we see that many of our States that need the most help are actually the red States.

Eighteen percent of the people in Tennessee and Utah don't have health insurance and cannot get the quality care they need. The number of uninsured stands at 20 percent in Alaska, and it is nearly 21 percent in Georgia, Florida, and Wyoming. In Oklahoma, Nevada, and Louisiana, more than 22 percent of the total population is uninsured, and 24 percent without health insurance in Mississippi. More than a quarter of the population in New Mexico can't get health insurance. In the great State of Texas, almost 27 percent of the population has no health coverage. These numbers speak for themselves. We need to expand coverage to include more of these people.

A recent study conducted by Harvard University shows that the uninsured are almost twice as likely to die in the hospital as similar patients who do have insurance. This human cost is unacceptable, and the financial cost is too much to bear.

While my friends on the other side seek to delay and derail health care reform at this crucial juncture, this bill seeks to save the health of our citizens, to save the lives of Americans, and to save the money they will spend on health care. It is offered and delivered. By extending coverage to these individuals and increasing access to preventive care, we can...
Mr. DURBIN. Can the Senator give us an indication of how long he expects the colloquy to last?

Mr. ENSIGN. Maybe 40 minutes, somewhere in there.

Mr. DURBIN. I thank the Senator. Mr. ENSIGN. Mr. President, there is no indication of how long he expects the colloquy to last?

Mr. ENSIGN. Mr. President, I would like to start by talking about the bill in general.

Mr. DURBIN. Mr. President, will the Senator from Nevada yield for a question before he starts?

Mr. ENSIGN. Yes.

Mr. DURBIN. Can the Senator give us an indication of how long he expects the colloquy to last?

Mr. ENSIGN. Maybe 40 minutes, somewhere in there.

Mr. DURBIN. Thank the Senator. Mr. ENSIGN. Mr. President, there is a lot of talk about this bill. I wish to make some general comments about it. First, or the comments of my colleague from Illinois, he said there are not $2 trillion in Medicare cuts. According to the Congressional Budget Office, there are $401 billion to $465 billion in Medicare cuts. So maybe not quite $2 trillion, but we are certainly getting close. There are, however, $1 trillion in new taxes in this bill, 84 percent of which will be paid by those making less than $200,000 a year, a direct violation of the campaign pledge made by President Barack Obama, then-Candidate Obama.

This bill will result in increased premiums and health care costs for millions of Americans. This is a massive government takeover of our health care system. As a matter of fact, according to the National Center for Policy Analysis, in this 2074 page bill—there are almost 1,700, 1,697 to be exact—references to the Secretary of Health and Human Services to create, determine, or define things relating to health care policy in this bill. Basically, we are placing a bureaucrat in charge of health care policy instead of the patient and the doctor making the choices in health care.

I believe we cannot just be against this bill. What I do believe in is a step-by-step approach, an incremental approach, some good ideas on which we should be able to come together.

I think both sides agree we should eliminate preexisting conditions. Somebody who played by the rules, had insurance, happened to get a disease, they should not be penalized, charged outrageous prices, or have their insurance dropped. I think we can all agree on that.

We should be able to agree that if you can buy auto insurance across State lines, you should be able to buy health insurance in the State where it is the cheapest. Individuals should be able to find a State that has a policy that fits them and their family and be able to buy it there. If you can save money and you happen to be uninsured, especially today, it seems to make sense. Let’s have that as one of our incremental steps.

I also believe this bill covers some of it, but I believe we need to incentivize people to engage in healthier behaviors. Twenty-five percent of all health care costs are caused by people’s behaviors. Let me repeat that. Three-quarters of all health care costs are driven by people’s poor choices in their behavior.

For instance, smoking. On average, it is around $1,400 a year to insure a smoker versus a nonsmoker. For somebody who is obese versus somebody with the proper body weight, it is about the same, $1,400 a year. For somebody who does their cholesterol versus somebody who does—let’s give incentives through lower premiums to encourage people to engage in healthier behaviors. That will save money for the entire health care system and our Country will have healthier people with better quality lives.

Currently, big businesses, because of the number of employees, are allowed to take advantage of purchasing power. We ought to allow individuals and small businesses to join together in
groups to take advantage of that purchasing power. They are called small business health plans.

I believe my colleagues are going to talk about an idea they have, something I talked about for years, the idea of medical liability reform. There are several models out there. They are going to talk about a loser pays model, which other countries have engaged in and they do not have nearly the frivolous lawsuits nor the defensive medicine we practice in this country.

How do you order unnecessary tests in the United States because of fear of frivolous lawsuits? Talk to any doctor, and they will tell you every one of them orders unnecessary tests simply to protect themselves against the possibility that a jury may say: Gee, why didn’t you order this test even though it was not indicated at the time?

That accounts for a large amount of medical costs. As a matter of fact, the Congressional Budget Office says $100 billion between the private and public sector would be saved with a good medical liability reform bill.

I believe we need a patient-centered health care system, not an insurance company-centered health care system, not what this bill does, a government-centered health care system, where bureaucrats are in control of your health care. We need a patient-centered system.

Before us we have the Mikulski amendment. This is more of government-centered health care. There is a report out based on prevention that indicates that mammograms should not be paid for, basically, for women under 50 years of age, from 40 to 50 years of age, and women in the Medicare population age, the report indicates that they do not need annual mammograms.

This was based mainly on cost. If you look at it from a cost standpoint, that is probably a good idea.

But think about it. If you are a woman and you get cancer and you could have had a mammogram diagnose it a lot earlier, you sure would rather have had that mammogram rather than have that mammogram denied.

The Senator from Maryland has proposed an amendment to try to fix the problem. The problem is, instead of one government entity determining whether someone is going to get coverage, the amendment turns it over to the Secretary of Health and Human Services. Another government bureaucrat will determine whether something such as a mammogram will be paid for. According to the Associated Press, her amendment does not even mention mammograms.

Senator MURKOWSKI and Senator COBURN have come up with an alternative that actually puts the decision of whether to order preventive services in the hands of experts in the field. Whether it be a mammogram for breast cancer, or an MRI, which most people think is going to be better than a mammogram for diagnosing breast cancer, or whether it is a test for prostate cancer for men. Those kinds of things should be determined by experts in the field, not by government bureaucrats.

The various colleges—the American College of Obstetrics and Gynecology, for instance, has come out with certain recommendations, along with the American College of Surgeons. Those are the experts with peer-reviewed evidence to determine the individuals who should determine what the recommendations are as to whether we pay for preventive services, not government bureaucrats.

Unfortunately, the Mikulski amendment just gives that determination to a government bureaucrat. That is why we should reject the Mikulski amendment, and adopt the amendment offered by the Senator from Alaska, the Murkowski amendment puts the decision making of this list of the experts, where that decision should be made.

Let me close with this point. We have seen a lot of comparisons where people say that other countries have a better health care system than the United States. Let me give you the example of cancer survival rates.

This chart compares the average cancer survival rates in the European Union and the United States; it makes the point as to whether a government bureaucrat is making a health decision or the doctor and the patient are making the health treatment decision.

For kidney cancer, the European Union has a 56 percent 5-year survival rate; the United States, 63 percent survival rate after 5 years. On colorectal cancer, about the same difference between the United States and the European Union. Look at breast cancer, 79 percent after 5 years in the European Union; 90 percent in the United States.

The most dramatic difference is on prostate cancer, 78 percent survival after 5 years in the European Union; 99 percent survival rate in the United States.

These are dramatic differences. Where would you rather get your health care if you had one of these cancers? The United States or Europe?

Canada, has even worse results thus far. As a matter of fact, Belinda Stronach, a member of the Canadian Parliament, led the charge against a private system side by side with the government in Canada. She did not want the private system.

Tragically, a couple years later, she developed breast cancer. Did she stay in Canada to get treatment, where there is a government-run health care system? Did she go? She came to the United States. She was actually treated at UCLA. Why, because we have a superior system of quality in the United States.

We have a problem with cost. Some of the incremental steps I talked about will address costs.

I wish to turn it over now to my colleagues who are going to talk about medical liability reform. Let’s look out for the patient instead of the trial lawyers in the United States. Their idea on a loser pays system, I think, has a lot of merit, and it is something this body should consider very seriously.

Mr. CHAMBLISS. Mr. President, I thank the Senator from Nevada for yielding. Senator GRAHAM and I do have an amendment we have filed today with respect to reformatting the health care system in a real, meaningful way. It is an amendment that deals with tort reform, and it is a true loser pays system. We are going to talk about that in a few minutes.

Before I get to that, I wish to go back to some of the points the Senator from Nevada has talked about. I particularly appreciate his work on the mammogram issue, especially since this has been highlighted over the last couple weeks with regard to the recommendations that has come from the independent board that advises HHS. I thank him for his work on that issue.

He is dead on. All of us know our wives are told every year, when they reach a certain age, they need to have a mammogram to make sure. Just like we do every year, go in and get a physical, they need to get their mammogram. The Senator talks about those kinds of checkups providing you with the kind of preventive health care that is going to hold down health care costs. I am a beneficiary of that. During a routine medical examination in 2004, it was determined I had prostate cancer. I was very fortunate it was picked up when it was, at an early stage. Instead of having to go through a lot of expensive procedures I might have had to go through, we were fortunate to be able to treat it. We are working on getting cured.

Senator ENZI is exactly right, this is the kind of test we need to make sure we encourage females to get and not put barriers in front of them.

Medicare is such a valuable insurance policy and program that 40 million Americans today take advantage of it. Mr. President, 1.2 million Georgians are Medicare beneficiaries. Again, I am one of those who is a Medicare beneficiary. So this is particularly important to me.

More importantly, in addition to those 12 million Medicare beneficiaries who are in the country today, there are another 80 million baby boomers who are headed toward Medicare coverage.

We have an independent Medicare Commission that was established by Congress years ago that is required to come to Congress every year and give Congress an update on the financial solvency of the Medicare Program. The purpose of that bipartisan Commission is to allow this body, along with our colleagues over in the House, the benefit of the work they are doing in looking at the amount of revenues that come in, in the form of the Medicare tax, and the outlays that go out, in the
form of payments to medical suppliers for our Medicare beneficiaries.

In the spring of this year, 2009, the independent Medicare Trustees Report reported back to Congress and said that unless real, meaningful reforms are made in the Medicare system, Medicare is going to start going to a place where it will cost less to receive more in benefits than it takes in in tax revenues in the year 2017.

Mr. President, what that means is that in 2017, Medicare is going to be insolvent, and it is not a matter of time before Medicare goes totally broke. And those individuals who are baby boomers, who have been paying into this program for 40 years, 50 years, or whatever it may be, are all of a sudden going to reach the Medicare age, where they expect to reap the benefits of the Medicare taxes they have been paying for all these years, and guess what. Not only are benefits going to be reduced, but unless something happens, unless there is meaningful reform and it is done the right way, there is not going to be a Medicare Program.

I want to go back to something the junior Senator from Illinois said a few minutes ago. In talking about this issue of cuts in Medicare, he said this bill would not amount to what was filed by Senator REID does not have cuts in Medicare. He could not be more incorrect. And that is not a Republican statement. It is not a statement by anybody other than the Congressional Budget Office because what you would find has already been introduced during the course of this debate—a letter dated November 18—to the Honorable HARRY REID, the majority leader. I would refer the Senator to page 10 of that letter in which the Director of the Congressional Budget Office says this in reference to provisions affecting Medicare, Medicaid, and other programs:

Other components of the legislation would alter spending under Medicare, Medicaid and other programs. In total, the net impact of provisions that reduce direct spending by $491 billion over the 2010-2019 period.

Then the letter goes on, on this page alone, to delineate three areas where Medicare provisions are going to be reduced or cut, and I would specifically refer to them, but first is a fee-for-service sector, and this is other than physician services. It is going to be reduced by $192 billion over 10 years. The Medicare—I mean, I hate to bring it up, but the Medicare—I mean, I don’t know about your family, but I have a particular personal story myself. My father-in-law died when he was 99 years old. It was 3 years ago. The last 2 years of his life, he lived in an assisted-living home and he had hospice available to him in 24 hours when he needed it. Had he not had the benefit of hospice, he would have had to go in a hospital, and no telling how much in the way of Medicare medical expenses he would have incurred.

But thank goodness we had hospice available, and he spent 2 days in the hospital. Otherwise, he was able to live with him in an assisted-living home, have my wife do and spend quality time with him, which she will tell you today was the best 2 years of her life as far as a relationship with her father was concerned, because she had hospice there to take care of him. Yet here we are talking about reducing a benefit by $5 billion that saved no telling how many thousands of dollars in the case of my family, and you can multiply that across America, and it is pretty easy to see we don’t need to be reducing a benefit that is going to save us money in the long run.

I would like to turn it over to my friend from South Carolina, who also has some comments regarding Medicare, and then we will talk about our loser pays bill.

Mr. GRAHAM. I thank my friend from Georgia, and I will try to be brief. I guess to say that we need to do health care reform is pretty obvious to a lot of people. The inflationary increases in the private sector, to businesses, to doctors, to health care area, are unsustainable. A lot of individuals are having to pay for their own health care costs and are getting double-digit increases in premiums. In the public sector, the Medicare and Medicaid programs are unsustainable. Medicare alone is $38 trillion under-funded.

Over the next 75 years, we have promised benefits to the baby-boom generation and current retirees, and we are $38 trillion short of being able to honor those benefits. What has happened? We have created a government program that everyone likes, respects, and is trying to save, and actuarially it is not going to make it unless we reform it. So what have we done? In the name of health care reform, we have taken a program many seniors rely upon—all senior citizens, practically—and we have reduced the dollars that are going to spend on that program and then taken the money from Medicare to create another program the government will eventually run. It makes no sense.

We need to look at saving Medicare from impending bankruptcy. Why would we reduce Medicare by $464 billion and take the money out of Medicare, which is already financially in trouble, to create a new program? It makes no sense to me. That is not what we should be trying to do, from my point of view, to reform health care.

The Medicare cuts Senator Chambliss was talking about, they are real. The way our Democratic colleagues and friends are trying to create another program the government is going to spend on that program and then take the money from Medicare to offset the spending that is required by that bill. Here is the question for the country: How many people in America really believe this Congress or any other Congress is actually going to reduce Medicare spending by $464 billion over 10 years? I would argue that if you believe that, you should not be driving. There is absolutely no history to justify that conclusion.

In the 111th Congress, there were 200 bills proposed—9 and I was probably on some of them—to increase the amount of payments to Medicare. In 1997, we passed a balanced budget agreement when President Clinton was President slowing down the growth rate of Medicare. That worked fine for a while, doctors started complaining, along with hospitals, about the revenue reductions. Every year since about 1999, 2000, we have been forgiving the reductions that were due under the balanced budget agreement because none of us want to go back to our doctors and say we are going to honor those cuts that were created in 1997 because it is creating a burden on our doctors. Will that happen in the future? You better believe it will happen in the future. In 2007, Senator Kennedy and GREGG introduced an amendment to reduce Medicare spending by $33.8 billion under the reconciliation instructions. It got 30 votes. I remember not long ago the Republican majority proposed reducing Medicare by $10 billion. Not one Member of the Democratic Senate voted for that reduction. They had to fly the Vice President back from Pakistan to break a tie over $10 billion. So my argument to the American people is quite simple. We are not going to reduce Medicare by $464 billion, and if we don’t do that, the bill is not paid for, and that creates a problem of monumental proportions. If we
do reduce Medicare by $404 billion and take the money out of Medicare to create another government program, we will do a very dishonest thing to seniors. We are damned if we do and damned if we don’t. And during the whole campaign, I don’t remember anybody suggesting that we needed to get Medicare to create health care reform for non-Medicare services, but that is exactly what we are doing.

To my Democratic colleagues: There will come a day when Republicans and Democrats will have to come down and seriously deal with the underfunding of Medicare and with the impending bankruptcy of Medicare. Everything we are doing in this bill may make sense to save Medicare from bankruptcy, but it doesn’t make sense to pay for another government-run health care program outside of Medicare. It makes no sense to take the savings we are trying to find in Medicare and not use them to save Medicare from bankruptcy or any special interest group. So I think that is going to be a budget disaster.

So let it be said that this attempt to pay for health care, to make it revenue neutral, will require the Congress to do something with Medicare that it has never done before. Is this worth it? Never to do it. Never to do it. And our patients are not indigent. It is not the indigent who are going to bear a greater burden. It is the middle income family which will bear a greater burden.

As to the indigent person, most people who are not indigent. The judge has the ability to modify the consequences of a loser pays rule, but we need to know going in that both wallets are on the table. Under our proposal, we have mandatory arbitration where the doctor and the patient will submit the case to an arbitration panel. If either side turns down the recommendation of the panel, they can go to court. But then the loser pays rule kicks in.

I think that will do more to weed out frivolous lawsuits than arbitrarily capping what the case may be worth in the eyes of a jury. I think it really does create a financial incentive not to bring frivolous lawsuits that does not exist today.

If the goal is a $500,000 damage cap, most of the people I know would say: I will take the $500,000. That is not much of a deterrent. But if we told someone that they can bring this suit if the arbitration didn’t go their way, but if they go to court, but if they lose, they risk one of their financial assets, people will think twice. I think that is why this is a good idea. The National Chamber of Commerce has endorsed it, and I am proud of the fact that they have endorsed it.

I would rather not go down this road, but if we are going to nationalize health care we also need to do something about the legal system that is going to be affected by the nationalization of health care.

A final comment I would like to make about what we are doing is that it is probably worrisome to people at home that we are about to change one-sixth of the economy and cannot find one Republican vote to help. I guess there are two ways to look at that: It is the problem of the Republican Party or maybe the bill is structured in a way that is so extreme there is no middle to it. I would argue that what we have is a problem of the extreme. It is pretty extreme, in my view, to take a country that is so far in debt you cannot see the future and add $2.5 trillion of more debt onto that nation that is already debt laden in the name of reforming health care.

When you look at the second 10-year window of this bill, it adds $2.5 trillion to the national debt. Is that necessary to reform health care? Do we need any more money spent on health care or should we just take what we spend and spend it more wisely? The first 10 years is a complete gimmick. What we do in the first 10 years of this bill is collect the $4 trillion in taxes for the 10-year period, and we don’t pay any benefits until the first 4 years are gone. That is a gimmick.

And that is going to be a problem with the health care system, if that is going to be a problem. That is interesting, in my view, to take a country that is so far in debt you cannot see the future and add $2.5 trillion of more debt onto that nation that is already debt laden in the name of reforming health care. When you look at the second 10-year window of this bill, it adds $2.5 trillion to the national debt. Is that necessary to reform health care? Do we need any more money spent on health care or should we just take what we spend and spend it more wisely? The first 10 years is a complete gimmick. What we do in the first 10 years of this bill is collect the $4 trillion in taxes for the 10-year period, and we don’t pay any benefits until the first 4 years are gone. That is a gimmick.

And that is going to be a problem with the health care system, if that is going to be a problem. That is interesting, in my view, to take a country that is so far in debt you cannot see the future and add $2.5 trillion of more debt onto that nation that is already debt laden in the name of reforming health care.
Florida, which applied a loser pays rule to medical malpractice suits from 1981 to 1985, saw 54 percent of their plaintiffs drop their suits voluntarily.

It does make a difference on frivolous suits. In the State of Florida during that same period of time, the jury awards for plaintiffs rose significantly. Just as in our situation, anybody who had a legitimate case in Florida during that period of time had the right to have their case adjudicated by a jury. Those who made the decision to do so received more significant awards. That is the way the system ought to work.

This is a win-win situation for the cost of health care delivery. It is a benefit to the physicians—sure, because they eliminate part of their significant cost of delivering health care services. But it also is a huge benefit to those individuals in America who are subject to negligent acts on the part of physicians.

I ask unanimous consent that a letter from Senator Graham and myself from Bruce Josten at the U.S. Chamber of Commerce, dated November 3, 2009, be printed in the RECORD, and I yield the floor.

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

**November 3, 2009.**

Hon. LINDSEY GRAHAM, U.S. Senate, Washington, DC.

Hon. SAXBY CHAMBLESS, U.S. Senate, Washington, DC.

Dear Senators Graham and Chambliss:

The U.S. Chamber of Commerce, the world’s largest business federation representing more than three million businesses and organizations of every size, sector, and region, thanks you for introducing S. 2662, the “Fair Resolution of Medical Liability Disputes Act of 2009.”

This legislation represents a positive and significant step toward providing a more reliable justice system for the victims of medical malpractice. Your bill encourages the states to adopt a non-binding alternative manner for resolving medical liability claims and provides them with the latitude to develop unique approaches that fit the needs of their diverse populations. The Chamber commends you for making this important and thoughtful effort to bring needed reforms to America’s medical liability systems.

The issue of medical liability reform is central to any serious effort to overhaul America’s healthcare system. The Congressional Budget Office recently determined that without health reform would result in a total national healthcare spending by $11 billion in 2009 and reduce the federal budget deficit by $54 billion over 10 years. The Chamber’s estimates of healthcare savings may be too conservative. Yet nonetheless, the $54 billion in deficit reduction is significant, representing over 10 percent of the net cost of the insurance coverage provisions agreed to in the Finance Committee’s “America’s Healthy Future Act of 2009.” We are confident that you will be a forceful advocate for medical liability improvements that will expand access to justice for injured patients and lower the cost of healthcare.

There is bipartisan agreement that for healthcare reform to be successful, it must “bend the growth curve,” making healthcare delivery more efficient and slowing healthcare inflation. Medical liability reform should play a critical role in such an effort. The Chamber appreciates your work on this legislation and looks forward to working with you and the Senate in the coming weeks and months to refine your legislation and advance common sense changes to our system of resolving medical liability claims.

Sincerely,

R. Bruce Josten.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Could the Chair inform me how much time was used on the Republican side during the last group of speakers?

The PRESIDING OFFICER. That was 42 minutes 14 seconds.

Mr. DURBIN. I thank the Chair. I am going to proceed to speak in the same manner and yield to the Senator from Vermont. Our time will be less than that in total.

I see the Senator from Louisiana is here. We are going to be speaking less than 42 minutes. We guarantee him that much. We will follow the same process, if there is no objection, that was just followed with three Republican speakers who spoke in that 42-minute period of time.

I ask unanimous consent that Senator Sanders be recognized after me to speak and that our total time be no more than 42 minutes.

Mr. VITTER. Objection?

Mr. DURBIN. I object.

Mr. VITTER. Objection is heard.

Mr. DURBIN. Mr. President, I just offer that to the Republican side, and they asked me for permission and I gave permission, unanimous consent.

We will speak as long as we like. We will enter into a colloquy. I hope the Senator from Louisiana will reconsider.

Let me try to address a few of the issues that have been raised on the Senate floor. First, the issue of medical malpractice, this is an issue often brought up on the other side of the aisle.

The first thing I would like to say is this is the bill we are debating. It is 2,074 pages, and one extra page makes it 2,075 pages. It has taken us a year to put this together. There have been a series of committee hearings that have led to the creation of this legislation. It has been posted on the Web site for anyone interested. If they go to Google, for example, and put in “Senate Democrats,” they will be led to a Web site which will let them read every word of this bill. It has now been out there for 12 days at least, and it will continue to be there for review by anyone interested.

If you then Google “Senate Republicans” and go to their Web site on health care and look for the Senate Republican health care reform bill, you will find—this bill, the Democratic bill, because there is no Senate Republican health care bill. For a year, and with an enormous number of speeches, they have come to the floor and talked about health care but have never sat down and prepared a bill to deal with the health care system, which leads us to several conclusions.

This is hard work and they have not engaged in that hard work. It is easier to criticize a bill that does not exist. They have chosen that route. That is their right to do. This is the Senate. We are the majority party. We are trying to move through a bill. But all of the ideas they have talked about tonight and other evenings have not resulted in a bill.

Second, it may be that they do not want to see a change in the current system; they are happy with the health care system as it exists today. That is possible. In fact, I think it drives some of them to the point where they criticize our bill but do not want to change the system because they like it.

I guess there are some things to like about it. There are good hospitals and good doctors in America. Some people are doing very well with the current system. But we also know there are some big problems. We know the current system is not affordable. We know the cost of health insurance has gone up 131 percent in the last 10 years; that 10 years ago a family paid about $6,000 a year for health insurance. Now that is up to $12,000 a year. We anticipate in 8 years or so it will be up to $24,000 a year. Roughly 40 percent or more of a person’s gross income will be paid in health insurance.

The Chamber has proposed that to the Republican side, and they have chosen that route. That is their right to do. This is the Senate. We are the majority party. We are trying to move through a bill. But all of the ideas they have talked about tonight and other evenings have not resulted in a bill.

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That is absolutely unsustainable. So businesses are unable to offer health insurance as well as individuals are unable to buy health insurance. The Republicans have not proposed anything, nothing that will make health insurance more affordable. This bill addresses that issue. They have nothing.

Second, we know there are about 50 million Americans without health insurance. These are people who work for businesses that cannot offer a benefits package. They are people who are recently unemployed, and they are people in such low-income categories they cannot afford to buy their own health insurance, and their children—50 million. This bill we have before us will give coverage to 94 percent of the people in America, the largest percentage of people insured in the history of our country.

The Republicans have failed to produce a bill that expands coverage for anyone in America. Under the Republican approach, nothing would be done to help the 50 million uninsured.

The third issue is one about health insurance companies. Everybody has an experience there. It is, unfortunately, not good for most, because when you pay premiums all your life and then need the health insurance, many times it is not there. What we do is give consumers bargaining power and a fighting chance with health insurance. That is our paid-up approach. It eliminates discrimination against people because of a preexisting condition and putting caps on the...
The Republicans fail to offer anything that deals with health insurance reform. That is a fact. They have said a lot about Medicare.

I would like to tell you that tomorrow, so will be cosponsoring and Senator BENNET of Colorado will be offering an amendment which could not be clearer on the issue of this bill and the Medicare Program. The amendment is so short and brief and direct and understandable, I want to read a couple of highlights:

Nothing in the provisions of, or amendments made by, this Act shall result in the reduction of guaranteed benefits under title XVIII of the Social Security Act.

That is Medicare. What Senator BENNET is saying is that people will have their Medicare benefits guaranteed. Nothing in this bill will infringe on their Medicare benefits, despite everything that has been said.

The Bennet amendment goes on to say:

-Savings generated for the Medicare program under title XVIII of the Social Security Act, and amendments made by, this Act shall extend the solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, expand guaranteed Medicare benefits and protect access to Medicare providers.

All of the speeches made in the last 3 days about how this bill threatens Medicare—it does not—will be completely cleared up by the Bennet amendment. I hope some Republicans who have a newfound love of the Medicare Program, which was started many years ago, will join us in voting for this amendment. It would be great to see if their love for Medicare would result in their votes for the Bennet amendment. This is a critically important amendment. I commend him for being so straightforward and showing real leadership on an issue of this magnitude.

I know the Senator from Vermont is interested in speaking. I am prepared to yield for comments and questions. Before I do, I wish to say by way of introduction that we heard one of our Republican friends talk about how this current health care system is that we have right now. I ask my friend from Illinois, do you think we can do better than being the only major country in the industrialized world that does not guarantee health care to all its people? Can we do better than that?

Mr. DURBIN. In response to the Senator from Vermont, we must do better. This is the only civilized, developed, industrialized country in the world where a person can literally die because they don’t have health insurance. Forty-five thousand people a year die because they don’t have health insurance. What does that mean? One illustration: If you had a $5,000 copay on your health insurance—and God help the people face that—and you go to the doctor and the doctor says: Durbin, we think you need a colonoscopy, and I realize I have to pay the first $5,000 and the colonoscopy is going to cost $3,000, and I say I am going to skip it—which people do, and bad things happen—I develop colon cancer and die, my insurance has failed me. Basic preventive care is not there. We are the only civilized, developed country where that is a fact.

Mr. SANDERS. I ask my friend from Illinois, has he talked to physicians who have, on that issue, told him that they have lost patients who walked into their office and they say: Why didn’t you come in here 6 months ago or a year ago? And that patient says: I didn’t have any money, and I thought maybe the pain in my stomach or my chest would get better.

I have had that conversation with physicians. I wonder if the Senator has talked to physicians who have said the same thing.

Mr. DURBIN. A lady I met 2 weeks ago in southern Illinois, 60 years old, a hostess at a hotel who serves breakfast in the morning—they are there as we travel around our States—has never had health insurance in her life, is diabetic, and told me that her income is so low, $12,000 a year, she could not afford to go to a physician to check out some lumps she had discovered. That is the reality of the health care system in the wealthiest, greatest nation on Earth.

Mr. SANDERS. We have heard discussions of death panels. I think the Senator might agree with me that when we talk about death panels, we are talking in reality about 45,000 people who die every single year because they don’t get to a doctor on time. That seems to me to be what a death panel is.

In the midst of all this, with 46 million uninsured, with 45,000 people dying every year because they don’t get to a doctor when they should, when premiums have doubled in the last 9 years, when we have almost 1 million Americans going bankrupt because of medically related bills, I ask my friend from Illinois, isn’t it time for a change? Isn’t it time this country now moves forward and provides health care for all of our people? Can we do better than that?
was they were paying, and said: We are all on our own now. We have to go in the private market. The couple with the sick baby couldn’t find any health insurance. My friend, who was in his 60s, and his wife are in a pitched battle every year about how much they have to pay for health insurance and the company, the only one that will cover them, each year excludes whatever they turned a claim in for last year. So that is the reality of health insurance for small businesses.

I also want to tell my friend from Vermont, about one-third of all realtors in America are uninsured, have no health insurance. They are independent contractors, and they have no health insurance, one out of three.

Mr. SANDERS. While we are talking about the economics of health care, I wonder if my friend from Illinois has had the same experience I have had in Vermont where people tell me they are staying in their job not because they want to stay on their job but because the job is providing decent health insurance. They can’t go where they want to go because the new job may not provide insurance or they are afraid about the interval when they may have to change health insurance plans, and so on. I wonder if my friend from Illinois happened to see the piece in the paper, unbelievable, where a middle-aged fellow joined the U.S. military because his wife was suffering from cancer, and he couldn’t get health coverage for his wife so he joined the military. Does the Senator think this is what should be going on in the greatest country in the world?

Mr. DURBIN. We can do better. I would say to those who call our plan a single-payer plan, what we are trying to do is to get fair treatment from private health insurance companies for consumers and families across America and to give them choices. The Senator from Vermont, who is familiar with the program, is part of the Federal Employees Health Benefits Program. So am I. Most Members of Congress belong to the program. Eight million Federal employees and Members of Congress are part of this program. It may be the best health insurance in America. And we can shop. I just got a notice in the mail that says open enrollment is coming. If you don’t like the way you were treated by your health insurance plan last year, you can pick a new plan. It is a generous plan, more money will be taken out of your check. If it is not, less money will be taken out. We can shop. What we do on the insurance exchanges in this bill is say to these Americans who wouldn’t otherwise have options, a not-for-profit health insurance plan to pick a new plan with lower costs that people can choose, if they care to. Giving people that choice, giving them an option to go shopping for the most affordable, best health insurance plan is what we enjoy as Members of Congress and what every American family should.

Mr. SANDERS. I ask my friend from Illinois, does he think some of our Republican colleagues are so threatened and so upset by giving the American people the option to choose a public Medicare-type plan as opposed to a private insurance plan? Do you think that maybe, just maybe, friends are more interested in representing the interests of the big private insurance companies rather than the needs of the American people?

Mr. DURBIN. I say to my colleague from Vermont, I am waiting for the first Republican Senator to offer an amendment to this bill to abolish Medicare. If they really believe that government health insurance is such a bad idea, they ought to step right up and show it.

Mr. SANDERS. I would say to my friend from Illinois that that is an interesting proposal and, in fact, I was almost thinking of offering an amendment to do that. We have a lot of people in this country who stand up and say: Get the government out of health care. Well, I think some of my Republican friends have kind of echoed that message. I do think that the Senator from Illinois is right. We may bring forward an amendment to allow our Republican friends to say: Let’s abolish the Veterans’ Administration. Because, as you know, that is a government-run program which most veterans in my State and I think around the country are very proud of. They think it is a good program. From what the statistics tell us, it is a very cost-effective way to provide quality health care to all of our veterans. Maybe we should bring forward an amendment to allow those who say get the government out of health care. If you want to abolish the Veterans’ Administration, go for it. And what about TRICARE. Maybe you want to abolish TRICARE. Go for it. Maybe you want to abolish SCHIP, which is providing high quality health insurance for millions of kids. Maybe we might work together and bring forth an amendment.

Let our Republican friends who say get the government out of health care, let them abolish the Veterans’ Administration, Medicare, SCHIP, Medicaid, let them do that. We will see how many votes they might get.

Mr. DURBIN. The Senator from Illinois is another way that Senators who loathe the idea of government-run health care plans can show personally their commitment to that idea, by coming to the floor and publicly announcing they will not participate in the Federally Qualified Community Health Centers Program which provides health insurance for Members of Congress. I have yet to hear the first Member, critical of government health plans, come forward and say: In a show of unity and personal commitment, I am going to opt out.

Mr. SANDERS. I suggest to my friend from Illinois that we could take it a step further. I go to the Capitol physician’s office. That is where I go. We pay extra money for it. I have Blue Cross/Blue Shield, but I go there. Do you know who runs the Capitol physician’s office, which I suspect the vast majority of the Members of Congress and I go to and get very fine primary health care?

Well, it is that terrible government agency, the U.S. Navy. So maybe some of our friends who are busy denouncing government health care might want to say they do not want to take advantage of that very fine, high quality health care, and that speaks for the whole military as well. While we are at it, maybe you should abolish health care for the U.S. military, which is all government run and, by the way, generally regarded as pretty good quality health care.

I would ask my friend his views on that.

Mr. DURBIN. I do not think you will hear that. I think you will hear a lot of speeches about socialized medicine, socialism, and the big reach of government.

When it comes right down to it, there is not a single Member from the other side who stepped up there fore, I will offer an amendment to abolish it. They will have their chance in this bill, and if they want to, they can. I do not think the people who have this coverage today would like to see it go away.

Mr. SANDERS. It might be an interesting amendment, I would say to my friend. There is another area where it is a semigovernment nonprofit, which I know the Senator from Illinois feels very strongly about, and that is the Federally Qualified Community Health Centers begun by Senator Kennedy over 40 years ago, where we now have over 1,200 community health centers all over this country. In fact, I know there is a heavily loaded bipartisan or tricornered way, because the Federally Qualified Community Health Centers provide quality health care and dental care and low-cost prescription drugs and mental health counseling.

I might say to my friend from Illinois, one of the provisions in that 2,000-page bill he is holding up legislation he and I and others have worked hard on, which is to substantially expand the Community Health Center Program into every underserved area in America. We talk about 46 million people being uninsured in this country. We have 60 million people who do not have access to a doctor on a regular basis.

If we expand the Community Health Center Program, if we expand to a significant degree the National Health Service Corps so we can help young people become primary health care physicians by paying off their very substantial medical debts, would my friend agree with me that this would be a major step forward in improving primary health care in America?

The Senator from Vermont has been a leader on this
issue. I can recall when President Obama came forward with his stimulus bill, the recovery and reinvestment bill, that the Senator from Vermont was one of the leaders to put additional funds in the bill to build clinics all across American rural areas. We represent, as I have said, the towns and the cities we represent as well—for the very reason the Senator mentioned: Because for a lot of people who I represent in downstate, southern Illinois, in some of the rural regions, it is a long drive to a doctors clinic, primary care. So these community health clinics, FHQA clinics, are going to offer people primary care.

I think as a result of this bill, when we enact it—and I feel very good about the enactment of this because I think we sense this is a moment in history we should not miss—we are going to see this network grow across America. And it has proven itself to be so good.

In the city of Chicago, I have visited these community health clinics. I will bet they do far better in Vermont than I find there—many times I will walk in the door. The administrator will be there. We will start talking. I will meet the doctors. I will meet the nurses. When I finally get a chance to drink a cup of coffee and talk to them for a few minutes, I say—and I mean it—if I were sick, I would feel confident walking into the front door of this clinic, that I would be in the best of hands—better than the most expensive clinic in my State.

Mr. SANDERS. My friend from Illinois makes the point. And I have visited virtually all of them in the State of Vermont. We have gone from 2 to 8, with 40 satellites. We have over 100,000 people in the State of Vermont who now use these Federally Qualified Health Centers.

I know my friend from Illinois is also aware that when you talk about health care, you have to talk about dental care.

Mr. DURBIN. Yes.

Mr. SANDERS. Because what is true in Vermont is true in Illinois. You have a whole lot of people who do not have access to a dentist, which these Federally Qualified Health Centers now provide, and mental health counseling, and low-cost prescription drugs.

So I thank my friend from Illinois. I am sure the Senator and I are going to work together to make sure we, in fact, are successful in keeping people out of the emergency room, keeping them out of the hospital, by enabling them to get the medical care they need when they need it. I look forward to working with my friend on that.

Mr. DURBIN. Mr. President, I ask unanimous consent that after any leader time on Thursday, December 3, and the Senate resumes consideration of H.R. 3590, it be in order for any of the majority or Republican bill managers to be recognized for a total period of time not to extend beyond 10 minutes, equally divided among them that the time until 11:45 a.m. be for debate with respect to the Mikulski amendment No. 2791 and the McCain motion to commit; and during this time it be in order for Senator MURKOWSKI to call up her amendment with respect to the McCain motion to commit; and in order for Senator BENNET of Colorado to call up amendment No. 2826, a side-by-side amendment with respect to the McCain motion to commit; that no other amendments or motions to commit be in order during the pendency of these amendments and motion; that at 11:45 a.m. the Senate proceed to vote in relation to the Mikulski amendment No. 2791; that upon disposition of the Mikulski amendment, the Senate then proceed to vote in relation to the Mikulski amendment; that upon disposition of these two amendments, the Senate continue to debate until 2:45 p.m. the Bennett amendment No. 2826 and the McCaın motion to commit, with the time equally divided and controlled between Senators BAUCUS and McCaın or their designees; that at 2:45 p.m., the Senate proceed to vote in relation to the McCaın motion to commit; that prior to the second vote in each sequence, there be 2 minutes of debate, equally divided and controlled in the
usual form; that each of the above referred amendments or motion be subject to an affirmative 60-vote threshold, and that if the amendments or motion do not achieve that threshold, then they be withdrawn; further, that if any of the above listed amendments or motion be agreed to, and the motion to reconsider be laid upon the table; further, that it be in order if there is a request for the yeas and nays to be ordered, that if the amendments or motion, regardless of achieving the 60-vote threshold, that if the yeas and nays are ordered, the vote would occur immediately with no further debate in order with respect to this particular consent.

The PRESIDING OFFICER. Is there objection?

Mr. VITTER. Mr. President, reserving my right to object.

The PRESIDING OFFICER. The Republican leader.

Mr. MCCONNELL. Mr. President, reserving the right to object, and I will not object. I would just like to point out with some difficulty actually on both sides getting to the two votes that are designated in this consent agreement.

Our side of the aisle, the Republican side of the aisle, was prepared to vote on both of those amendments tonight. Then a problem developed on the other side, which I understand because we had had a problem on our side earlier. But I do just want to make it clear that Republicans were prepared and fully ready and willing to vote on the two amendments in the consent agreement tonight.

Mr. President, I do not object.

Mr. VITTER. Mr. President, reserving the right to object.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. VITTER. Thank you, Mr. President.

Mr. President, I certainly concur with the distinguished majority whip's goal of more amendments and more votes. With regard to this very important screening and mammography issue, my goal has been a very focused one. I have a filed second-degree amendment that has a very simple, focused objective, which I believe is extremely non-controversial. I believe it would be supported by everyone in this body, and that is simply to ensure that there is no legal force and effect to the recent recommendations issued in November of 2009 by the U.S. Preventative Services Task Force with regard to breast cancer screening, mammography, and self-examination.

As everyone knows, those new recommendations were shocking in that they took a giant step back from the previous recommendations and took a giant step back in terms of recommended screening, which virtually every expert I know of strongly disagrees with. So this filed, simple second-degree amendment simply says that those new recommendations of November of this year have no force and effect. I will read the amendment. It is very short. To be clear, it does nothing more than that.

[For the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

So we are simply ensuring that those new recommendations—which I strongly disagree with, experts strongly disagree with, I believe all of my colleagues do—have no legal force and effect. So I would simply ask that the unanimous consent proposed be modified so that the Mikulski amendment incorporates this language. I would propose that as an alternative unanimous consent request.

The PRESIDING OFFICER. Is there objection to the request, as modified?

Mr. DURBIN. I object.

The PRESIDING OFFICER. Objection is heard.

Is there objection to the original request from the Senator from Illinois?

Mr. VITTER. Yes, I continue to reserve my right to object. I am very disappointed about objecting to this important and what should be non-controversial provision. I would suggest another solution, which is to take the unanimous consent request on the floor and modify it so there is simply a vote on this second-degree amendment, amendment No. 2808, immediately before the vote on the Mikulski amendment.

The PRESIDING OFFICER. Is there objection to the request, as modified?

Mr. DURBIN. Mr. President, reserving the right to object.

The PRESIDING OFFICER. The Senator from Illinois?

Mr. DURBIN. Mr. President, I am not sure I would support or oppose the amendment offered by the Senator from Louisiana, but this matter has been on the floor now for 3 days. I say to the Senator, there is a pending amendment here on your side of the aisle from Senator MURKOWSKI on this issue, and I would hope that the Senator has approached her to incorporate his language. I do not know if the Senator approached Senator Mikulski. But at this point we think what is being made at fairness on both sides, that there will be Democratic amendments and Republican amendments both offered—Mikulski and Murkowski and McCain and Bennet—and so I would object because I believe we have the basis for a fair agreement at this point.

The PRESIDING OFFICER. Objection is heard. Is there objection to the original request of the Senator from Illinois?

Mr. VITTER. Mr. President, reserving my right to object, again, I am very disappointed to hear that. I have approached both sides. Senator Murkowski has incorporated similar language, and I was hoping we could come together, 100 to nothing, to actually pass this on to the bill, whichever alternative tomorrow is voted up—and maybe they both will be—but whichever is voted up or whichever is voted down, I think it is very important to try to work in a reasonable way. I don't want these new task force recommendations to have any force and effect.

So let me propose a third and final alternative unanimous consent request that at these votes, but before cloture is filed on the pending matter, this amendment No. 2808 receive a vote on the Senate floor as a first-degree amendment to the underlying bill.

Mr. DURBIN. Mr. President, reserving the right to object, may I suggest to my friend from Louisiana, would you consider approaching Senators Mikulski and/or Murkowski the first thing tomorrow and see if they are prepared to work with you on this? This Mikulski amendment has been pending for 3 days.

Mr. VITTER. Mr. President, if I could—

Mr. DURBIN. Well, then, I object.

The PRESIDING OFFICER. Objection is heard.

Is there objection to the original request?

Mr. VITTER. Mr. President, reserving the right to object, if I can respond directly, I didn't mean to cut the Senator off. If he has any further statement, I will be happy to listen to it. But just so I can respond directly, the first thing today, I approached both those Members and everyone involved in this debate about this language and certainly the majority side has had this language for at least 7 1/2 hours. The equivalent of this language has been incorporated into the Murkowski amendment, but my hope is that the language be accepted in the Mikulski amendment because it is not clear which is going to be adopted. I don't see the great controversy here. So that was my hope. And that is why I approached those two Senators and the majority side 7 1/2 hours ago about it with specific language.

So I renew my last unanimous consent request I made in that spirit.

Mr. DURBIN. Reserving the right to object, the staff advises me that they think what is being made at fairness on both sides, that there is no legal force and effect to the recent recommendations issued in November of 2009 by the U.S. Preventative Services Task Force with regard to breast cancer screening, mammography, and self-examination.

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Mr. DURBIN. I object.

The PRESIDING OFFICER. Objection is heard.

Is there objection to the original request from the Senator from Illinois?

Mr. VITTER. Yes, I continue to reserve my right to object. I am very disappointed about objecting to this important and what should be non-controversial provision. I would suggest another solution, which is to take the unanimous consent request on the floor and modify it so there is simply a vote on this second-degree amendment, amendment No. 2808, immediately before the vote on the Mikulski amendment.

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Mr. DURBIN. Mr. President, reserving the right to object.

The PRESIDING OFFICER. The Senator from Illinois?

Mr. DURBIN. Mr. President, I am not sure I would support or oppose the amendment offered by the Senator from Louisiana, but this matter has been on the floor now for 3 days. I say to the Senator, there is a pending amendment here on your side of the aisle from Senator Mikulski on this issue, and I would hope that the Senator has approached her to incorporate his language. I do not know if the Senator approached Senator Mikulski. But at this point we think what is being made at fairness on both sides, that there will be Democratic amendments and Republican amendments both offered—Mikulski and Murkowski and McCain and Bennet—and so I would object because I believe we have the basis for a fair agreement at this point.

The PRESIDING OFFICER. Objection is heard. Is there objection to the original request of the Senator from Illinois?

Mr. VITTER. Mr. President, reserving my right to object, again, I am very disappointed to hear that. I have approached both sides. Senator Mikulski has incorporated similar language, and I was hoping we could come together, 100 to nothing, to actually pass this on to the bill, whichever alternative tomorrow is voted up—and maybe they both will be—but whichever is voted up or whichever is voted down, I think it is very important to try to work in a reasonable way. I don't want these new task force recommendations to have any force and effect.

So let me propose a third and final alternative unanimous consent request that at these votes, but before cloture is filed on the pending matter, this amendment No. 2808 receive a vote on the Senate floor as a first-degree amendment to the underlying bill.

Mr. DURBIN. Mr. President, reserving the right to object, may I suggest to my friend from Louisiana, would you consider approaching Senators Mikulski and/or Murkowski the first thing tomorrow and see if they are prepared to work with you on this? This Mikulski amendment has been pending for 3 days.

Mr. VITTER. Mr. President, if I could—

Mr. DURBIN. Well, then, I object.

The PRESIDING OFFICER. Objection is heard.

Is there objection to the original request?

Mr. VITTER. Mr. President, reserving the right to object, if I can respond directly, I didn't mean to cut the Senator off. If he has any further statement, I will be happy to listen to it. But just so I can respond directly, the first thing today, I approached both those Members and everyone involved in this debate about this language and certainly the majority side has had this language for at least 7 1/2 hours. The equivalent of this language has been incorporated into the Murkowski amendment, but my hope is that the language be accepted in the Mikulski amendment because it is not clear which is going to be adopted. I don't see the great controversy here. So that was my hope. And that is why I approached those two Senators and the majority side 7 1/2 hours ago about it with specific language.

So I renew my last unanimous consent request I made in that spirit.

Mr. DURBIN. Reserving the right to object, the staff advises me that they think what is being made at fairness on both sides, that there is no legal force and effect to the recent recommendations issued in November of 2009 by the U.S. Preventative Services Task Force with regard to breast cancer screening, mammography, and self-examination.
Is there objection to the original unanimous consent of the Senator from Illinois?

Mr. VITTER. Mr. President, reserving the right to object, merely to respond through the Chair, I would say I have been working in that spirit. I have given the language to the majority side. I have been working both at the staff level and Member level with many folks. This should be non-controversial. I don’t know of any Senator who disagrees with this. So I will accept that offer. I will not object to this pending unanimous consent, but I truly hope the offer is made in good faith because I believe, when anyone reads this language, they will agree with it.

Again, it simply says these latest recommendations by the U.S. Preventive Services Task Force, made 2 weeks ago, will not have any legal force and effect. I believe all of us—certainly, it is my impression and, I guess, we will find out tomorrow morning—I believe all of us want to stop them from having force and effect because it is a great step backward in terms of breast cancer screening and mammography and even education about self-examination.

So I certainly take that offer and look forward to the majority side re-reading this language and hopefully accepting it tomorrow morning because I can’t imagine, on substantive grounds, objecting to the language.

Thank you. With that, I will not object.

The PRESIDING OFFICER. Without objection, the request from the Senator from Illinois is agreed to.

Mr. DURBIN. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. DURBIN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

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

AMENDMENT NO. 298 TO AMENDMENT NO. 291

Mr. DURBIN. Mr. President, I ask unanimous consent that the previous order with respect to H.R. 3590 be modified to provide that the Vitter amendment No. 291 be agreed to and the motion to reconsider be laid upon the table; that the order be further modified to provide that the vote with respect to the Mikulski amendment should now reflect the Mikulski amendment, as amended.

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

The amendment (No. 298) was agreed to, as follows:

(Purpose: To prevent the United States Preventive Service Task Force recommendations from restricting mammograms for women)

On page 2 of the amendment, after line 15 insert the following:

“(5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.”

MORNING BUSINESS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak therein for up to 10 minutes each.

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

REMEMBERING MARY JOSEPHTINE OBERST

Mr. MCCONNELL. Mr. President, today I rise to honor the life of a Kentucky heroine, Ms. Mary Josephine Oberst of Owensboro. Ms. Oberst passed away on November 13, 2009, at the age of 95. A native Kentuckian, she proudly served her country as a member of the Army Nurse Corps beginning in 1937. In July 1941, Ms. Oberst was sent to the Philippines, and in early 1942, the following year, when Bataan and Corregidor fell to the Japanese during the Battle of the Philippines, more than 60 nurses, including Ms. Oberst, were taken as prisoners of war, POWs, by the Japanese. These nurses, later christened the “Angels of Bataan,” were held as POWs for 33 months. During this time, Ms. Oberst continued her duties as a nurse, caring for fellow prisoners, even though she herself suffered from malaria and significant weight loss. In early February 1945, the 44th Tank Battalion rescued the POWs who were later brought back to the United States.

After overcoming the medical conditions which resulted from her imprisonment, Ms. Oberst was appointed captain and continued to serve as a member of the Army Nurse Corps. She worked in hospitals in Louisville, KY; Fort Knox, KY; and Ashford, WV, until her retirement from the Corps in 1947.

Ms. Oberst was honored for her duty with several military service awards, including the Bronze Star Medal. Mary Josephine Oberst was a woman of high character, who faithfully served our country. Today, I wish to honor her life and her service, as well as give my condolences to her family for their loss.

AMINATOU HAIDAR

Mr. LEAHY. Mr. President, I want to bring to the attention of Senators who may not already be aware, a situation that has been unfolding in Morocco and the Canary Islands.

Last year, I had the privilege of meeting Ms. Aminatou Haidar, called by some the “Saharawi Gandhi,” who received the 2008 human rights award from the Robert F. Kennedy Center for Justice and Human Rights. Ms. Haidar is a focus of attention again today because she is on a hunger strike in the Canary Islands after being summarily deported by the Moroccan Government on her way home to Western Sahara from the United States, where, coincidentally, she had been to receive the “Civil Courage Prize” from the Train Foundation.

Ms. Haidar is no newcomer to difficulties with the Moroccan authorities. She was first imprisoned in 1987 when she was a 20-year-old college student, after calling for a vote on independence for Western Sahara. She was released after 4 years, during which she was badly mistreated, she continued her advocacy for the right of the Saharawi people to choose their own future.

Arrested again in 2005 and separated from her two daughters, she led a group of 37 other Saharawi prisoners on a 51-day hunger strike for better prison conditions, investigations into allegations of torture, and the release of political prisoners. Since her 2006 release, she has continued her nonviolent struggle, which has brought widespread attention to the cause of the Saharawi people. The United Nations Security Council has repeatedly endorsed a referendum on self-determination for the people of Western Sahara.

On November 13, when Ms. Haidar arrived at the airport in El-Ayoun, she was detained by Moroccan authorities. She was told that by insisting on writing her place of residence as “Western Sahara” on her immigration form, she was in effect waiving her Moroccan citizenship. Her passport was taken, and she was forcibly put on a plane without travel documents to the Canary Islands, a Spanish archipelago located 60 miles west of the disputed border between Morocco and Western Sahara.

She remains there at the airport, separated from her daughters, in the 17th day of a hunger strike, and her health is reportedly rapidly deteriorating. She has refused an offer of a Spanish passport, insisting that she be a “foreigner in her own country.” The Moroccan Government refuses to reinstate her passport. She is, in effect, a stateless person.

This is unacceptable. Article 12 of the International Covenant on Civil and Political Rights, which Morocco has ratified, states in part, “Everyone shall be free to leave any country, including his own. . . . No one shall be arbitrarily deprived of the right to enter his own country.”

The situation in Western Sahara is a difficult one for the Saharawi people and the Moroccan Government. It is a protracted dispute in which the international community has invested a great deal to try to help resolve, without success. I recall the time and energy former Secretary of State James Baker devoted to it. The solution he proposed was rejected by the Moroccan Government.

Morocco and the United States are friends and allies, and I have commended the Moroccan Government for
positive steps it has taken in the past to improve respect for human rights and civil liberties. On a recent trip to North Africa, Secretary Clinton was complimentary of Morocco’s efforts to reach a peaceful solution in Western Sahara. But the Saharawi people, including Aminatou Haidar, have passionately advocated for the right to self-determination, and the international community, including the U.N., has long supported a referendum on self-determination, which has thus far been blocked by the Moroccan Government.

I have no opinion on what the political status of Western Sahara should be, but I am disappointed that the Moroccan authorities have acted in this way because it only adds to the mistrust and further exacerbates a conflict that has proven hard enough to resolve. Nothing positive will be achieved by denying the basic rights of someone of Ms. Haidar’s character and reputation. Her right to travel and her right to return to her home and family is undeniably her right, and it is only right that we show her that it is our intent to have her return to her passport, readmit her, and not pass judgment on whether she is a refugee or not. I encourage the Moroccan authorities to reconsider their decision to deport Ms. Haidar, which roccan Government to reconsider its policy is entirely in the interest of the Western Saharan people, whose fundamental rights are denied, is to strive to defend those rights now and in the future.

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60TH ANNIVERSARY OF THE VOICE OF AMERICA’S UKRAINIAN SERVICE

Mr. CARDIN. Mr. President, for six decades the Voice of America’s, VOA, Ukrainian-language service has been providing an invaluable service through its consistent broadcasting of facts, comprehensive news and information to the people of Ukraine.

During the first four decades of its existence, the Ukrainian service reached a Ukrainian population starving for information under an extremely strictly controlled, propagandistic Soviet media environment. Ukrainians went to great lengths and some risks to overcome Soviet censorship, which included the jamming of VOA and other shortwave international broadcasting.

During the Cold War VOA Ukrainian provided its listeners with uncensored news about such monumental events as the Hungarian Revolution, the Prague Spring, rise of Solidarity, and the fall of the Berlin Wall. A variety of shows worked to open the outside world to Ukrainian listeners, including a Popular Music Show, a Youth Show, and the long running series Democracy in Action, which was about how democracy works in the United States.

The Ukrainian service also focused on developments within Ukraine itself. VOA broadcasts about Soviet human rights violations in Ukraine, including its coverage of activities of the Helsinki process. The Commission, gave sustenance to Helsinki Monitors and other Ukrainian human rights activists, especially those languishing in the gulag for daring to call upon the Soviet government to live up to its Helsinki Final Act obligations. They know they are forgotten. Furthermore, the Ukrainian service also provided objective information about the Chornobyl nuclear disaster and the development of Ukraine’s movement for democracy and independence, culminating in the December 1, 1991, referendum in Ukraine in which an overwhelming majority of Ukrainians voted for the restoration of their nation’s independence.

For nearly two decades since, VOA’s Ukrainian service has continued to fill an important role in Ukraine’s evolving democracy. VOA reported on the December 2004 and January 2005 elections and the U.S.’s considerable support and assistance for Ukraine, including in the dismantling of the nuclear arsenal it inherited from the Soviet Union. During the Orange Revolution, VOA Ukrainian helped to reassure millions of Ukrainians that their international community would not sanction electoral fraud.

As Ukraine has evolved, so has the Ukrainian Service. While no longer broadcasting on radio as it did for most of its 60 years, it reaches more Ukrainians than ever with daily broadcasts over Ukrainian television—something unthinkable during Soviet rule—and reporting on its website. It continues to report on what is happening in Ukraine, but also it continues to cover every aspect of American life and society. As Chairman of the Helsinki Commission, I recognize the critical role of VOA’s Ukrainian service in helping Ukraine fulfill its aspirations in becoming a more fully democratic, independent, and secure.

WORLD AIDS DAY

Mr. CARDIN. Mr. President, I rise today in recognition of World AIDS Day, an international commemoration held each year on December 1 to raise awareness of HIV and AIDS around the world. The theme for this year’s World AIDS Day is “universal access and human rights.”

Around the world, 33 million people were living with HIV in 2007, including 2.7 million new infections. In the U.S., more than 1.2 million people are infected with HIV. According to the Joint United Nations Program on HIV/AIDS, or UNAIDS, global reports indicated that 2 million people died from AIDS-related causes in 2007.

Globally, sub-Saharan Africa is the hardest-hit region when it comes to HIV infection, accounting for two-thirds of all people living with HIV and for three-quarters of AIDS deaths in 2007. Sadly, 75 percent of young people who are infected with HIV are girls living in sub-Saharan Africa.

According to the results of a global youth survey conducted in 99 countries, 50 percent of young people have a dangerously low level of knowledge about HIV. This knowledge gap is particularly disturbing when taking into account a UNICEF report that indicates that 4.9 million young people, ages 15-24, are living with HIV worldwide.

Despite these statistics, recent advances in prevention and treatment of HIV give hope for the future. Globally, approximately 38 percent of the 730,000 children under 15 who needed antiretroviral drugs to treat HIV in 2008 were receiving the necessary therapy according to UNAIDS. This is a huge increase from just a little over 10 percent in 2005.

The percentage of pregnant women living with HIV who received antiretroviral treatment to prevent mother-to-child transmission has increased from 9 percent in 2004 to 33 percent in 2007.

Despite recent improvements in treatment coverage and declining mother-to-child transmission of HIV, problems remain in preventing and treating the disease. In addition, the number of new HIV infections continues to outpace the advances made in treatment numbers for every two people put on antiretroviral drugs, another five become newly infected with the disease. Clearly, prevention measures are essential to continue the fight against HIV/AIDS.

No State in the U.S. is immune from the effects of HIV/AIDS, and the epidemic is deeply felt among Marylanders as well. At the end of 2007, Maryland had 28,270 people living with HIV and AIDS. That same year, Maryland ranked fourth in the U.S. for the number of AIDS cases per 100,000 people.

The Maryland Department of Health and Mental Hygiene has estimated that
there are between 6,000 and 9,000 Mary-
landers who are unaware that they are
infected with HIV. Of the 1.2 million
people in the United States who are es-
imated to be infected with HIV, as
many as 21 percent are unaware that
they have the virus.

To address this problem, it is crucial
that HIV screening be readily available
and accessible to everyone at little or
no cost. This will increase the rate of
diagnosis in individuals that have HIV
and will accelerate their treatment.

The Patient Protection and Afford-
able Care Act will address this need
and will help achieve the goals out-
lined by the theme of this year’s World
AIDS Day campaign of “universal ac-
cess and human rights.”

First and foremost, the bill elimi-
nates discrimination based on pre-ex-
isting conditions. Individuals with HIV
will no longer be rejected from insur-
ance coverage because of their disease.

The bill also encourages outreach to
enroll and underserved popu-
lations in Medicare and CHIP, in-
cluding adults and children with HIV/AIDS.
It provides personal responsibility edu-
cation grants to States to create HIV/
AIDS education programs for adoles-
cents.

The bill will also cover preventive
services recommended by the U.S. Pre-
ventive Services Task Force, including
HIV testing for all pregnant women.
This testing will be provided at no indi-
vidual cost, making it universally ac-
cessible to all women in the U.S. Test-
ing pregnant women for HIV is vital for
prevention efforts, allowing women
who test positive to begin antiretroviral
drugs to prevent trans-
smission to their baby.

Furthermore, the Mikulecky amend-
ment, which I have cosponsored, would
allow coverage for HIV testing for all
women, regardless of risk, based on ex-
pert recommendations from the Health
Resources and Services Administra-
tion.

The Patient Protection and Afford-
able Care Act also provides grants to
encourage training health care workers
to treat individuals with HIV/AIDS and
other vulnerable populations.

Because of the numerous provisions
in the bill that will help the prevention
and treatment of HIV/AIDS, several
groups have expressed their support for
the Patient Protection and Affordable
Care Act. Among the groups that I
have heard from is the HIV Medicine
Association, an organization re-
presenting 3,600 physicians, scientists,
and health care professionals who work
on the frontlines of the HIV/AIDS epi-
demic in communities across the coun-
try.

We must continue to fight HIV/AIDS,
and I urge my colleagues to support
the measures outlined in the Patient
Protection and Affordable Care Act
that will further our efforts to combat
this disease.

RECOGNIZING REAL SALT LAKE
SOCCER TEAM

Mr. HATCH. Mr. President, I rise and
offer my congratulations to the Real
Salt Lake soccer team, the newly
crowned champions of Major League
Soccer. While Utah has a number of
sports teams with proud traditions—
both college and professional—Real Salt
Lake has brought to my home
State its first major professional
championship since 1971, when the
Utah Stars won the ABA title.

Fans throughout the world
were able to watch the matches
in real time. Real Salt Lake came to
Utah in 2004 and faced difficulties
during its first three seasons. In just its
fourth season, however, Real Salt Lake
made an improbable run to the Western
Conference Finals, despite only sneaking
into the play-offs on the last day of the
regular season. They eventually lost that
game by a score of 1-0, but with their first
playoff appearance, and opening their
new world class soccer-specific sta-
dium, their future was filled with
promising signs.

In 2009 Real Salt Lake delivered on
that promise. Once again, it was the
last team to qualify for the playoffs
and was the lowest overall seed. De-
spite being given little hope to win the play-
offs, this team of overachievers sure
made some noise once they got there.
They quickly reeled off a string of con-
secutive upsets against glitzy oppo-
nents with well-established star
power. Overcoming adversaries, Real Salt
Lake had delivered the first championship of
its kind in Utah in nearly four decades—
and it couldn’t have come in a more ex-
citing fashion or to a more deserving
group of athletes.

In the end, it wasn’t the Galaxy
of stars that prevailed; it was Real Salt
Lake with star power that didn’t—
the words emblazoned on the sign in its
home locker room: “THE TEAM IS
THE STAR.” That teamwork was cer-
tainly on display in the title tilt
against Los Angeles. It was reflected in
Real Salt Lake Robbie Findley’s break-
out 64th-minute strike that knocked the
team’s overtime and penalty kick heroes
possible. It was reflected in the play of
Salt Lake goalkeeper and Cup final MVP Nick Rimando, who turned away
shots by Cuauhtemoc Blanco.

On November 22, the title game in
Seattle pitted the little-known up-
starts of Real Salt Lake against the
Western Conference champions, the
Los Angeles Galaxy and its mega-stars
Landon Donovan and David Beckham.
After 90 minutes of regulation play and
30 minutes of overtime, the game re-
mained scoreless. Rimando had finished
the tiebreaker shootout, Real Salt Lake emerged vic-
torious 5-4 as Donovan’s potential
game-tying spot kick sailed harmlessly
over the crossbar. Real Salt Lake had
delivered the first championship of
its kind in Utah in nearly four decades—
and it couldn’t have come in a more ex-
citing fashion or to a more deserving
group of athletes.

Considering these facts, it would
have been easy for Real Salt
Lake’s owner, Dave Checketts, coach
Jason Kreis and general manager Garth
Lagerwey—all of whom turned the
team into a champion despite the
naysayers who said it couldn’t be done.

Once again, I congratulate Real Salt
Lake on this accomplishment. Senator
BENNETT and I have introduced a reso-
lation expressing the Senate’s con-
gratulations for Real Salt Lake and I
urge my colleagues to offer their sup-
port.

Mr. BENNETT. Mr. President, I wish to
commend and congratulate Real
Salt Lake for winning the 2009 Major
League Soccer Cup. I am delighted to
do so, and feel it is a privilege to honor
the MLS Cup champions on the Senate
floor.

The story of Real Salt Lake is
more than just a story about a soccer
team capturing the MLS title; it is a
story about banding together to over-
come obstacles and defying the odds.
Real Salt Lake was well known to be
counterfeited by “the experts.” In many
ways, the story of Real Salt Lake is part
and parcel of the American experience.

On November 22, 2009, in Seattle, WA,
Real Salt Lake completed a stirring
run from last team to qualify for the
playoffs that would de-
fine the championship game. When asked
why they could win against the Galaxy in
the Eastern Conference finals, Real Salt
Lake’s MVP Nick Rimando, said, “We’ve
been easy for RSL to give up. But
have the league’s biggest stars. But in
the words of midfielder Clint Mathis,
better known as Cletus, RSL was “the
better team in every game.” As much
as anything else, that explains why
champion Real Salt Lake is now the
brightest light in Major League
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about their chances, head coach Jason Kreis sarcastically replied, “Wow, it sounds like we better not even go. We don’t even have a chance, do we?” He knew RSL possessed something special.

Even in the final match, such outspoken optimism could not be sustained. By halftime, RSL was trailing 1-0. Two of their key players were unable to continue playing, sidelined by injury and illness. If ever there was a time to give up, it seemed that this was it. But that wasn’t their attitude. Coach Kreis made a pair of substitutions, and encouraged his players to “be confident,” and play aggressively. And, well you can see where this is going. After 90 minutes of play, 30 minutes of overtime, and several rounds of penalty kicks that included two blocked shots by RSL goalkeeper Nick Rimando, defender Robbie Russell converted the final penalty kick to seal the victory, establishing RSL as the champions of Major League Soccer.

Now I wish to place this victory into some context. This was significant for Utah in that it was the first professional sports crown to go to the State of Utah since the Utah Stars basketball team won the American Basketball Association title back in 1971. RSL’s victory was notable not only because Jason Kreis, at the age of 36, became the youngest manager in MLS history to lead his team to the title, but also because RSL became the first franchise in professional sports history to win a championship after finishing the regular season without a winning record. Think about that for a minute—if there is ever a reason to dismiss a team, a losing record in the regular season should be it. But that wasn’t RSL’s attitude. Rather than dwelling in self-pity and regret, RSL fought on, determined to prove their detractors wrong. They believed they could beat the entire league, and they went out and did just that. Their story exemplifies the American values of hard work, resilience, and overcoming the odds.

Once again, I congratulate RSL for their victory; I join with their fans in celebration of this championship; and I hope that this is one of many more championships to come for Utah.

Mr. BAUCUS. Mr. President, today I wish to speak about the life lessons we learn from participating in athletic activities. I wish to speak about the coaches who taught us these lessons; about the young athletes, Michael T. Powers, author of many inspirational books once said, “High school sports: where lessons of life are still being learned, and where athletes still compete for the love of the game and their team’s honor.” High school sports are a way of life across Montana and they create an important sense of community in small towns and cities all over Big Sky country. In many areas across the state, small high schools will pool their resources to field football teams each fall; many play six or eight man games.

This year Ed Flaherty, a native Montanan co-authored the book “Coached for Life” about the experience he and his teammates had on the State champion Great Falls Central High School football team in 1962. I was inspired by the stories of these young men and how the lessons learned in the field from their coaches shaped who they became as people and their experiences later in life.

The young men that made up Great Falls Central’s 1962 Championship squad truly embody the best of Montana ideals and values, like hard work and taking responsibility. They labored tirelessly both on and off the field and achieved not only athletic glory, but also learned the value of a good education and how to be role models and ambassadors for their school. Great Falls has always been a working class town and many families made significant financial sacrifices to allow their children to attend Great Falls Central, a private Catholic school. Coaches Bill Mehrens and John “Poncho” McMahon, reminded the players each day that playing football at Central was a privilege and that they had a responsibility to their teammates, their school, and the community to give it their all on the practice field, in the game, and in the classroom. No doubt the coaches pushed these young men each and every day, they did it to instill discipline and to make them the best they could be.

The 1962 season was a special one for Great Falls Central. The goal of the team was to win the State championship. A year earlier, the coaches drove some of their players north 115 miles to the Big Sky country, in the Sparse Mountain championship game, not only to scout two of the best teams in the State but also to witness a championship win. The Central players took it all in and knew they wanted to be the ones holding up the trophy the following season. The Mustangs achieved that goal, making it through the 1962 season undefeated and beating their rival, the defending State Champions, Havre High 34-6 in the Montana Class A State championship game in front of more than 5,000 elated fans on their home field.

Having gone through this experience, the men later in life were able to rise up against the many challenges that were thrown their way. At a team reunion in 2002, 40 years after their championship run, the players and coaches gathered again to reflect and share their life stories. Some have gone on to be teachers and coaches, passing on the life lessons they learned from Mehrens and McMahon. Some, like Ed Flaherty, have achieved successful careers in business and in turn gave back to their communities. Some served their country heroically in the military. All have taken the lessons they learned from the fall of 1962 and have helped their communities and become leaders. Ed Flaherty has compiled these stories in his book and brings to life that amazing season and what it truly means to be coached for life.

TRIBUTE TO HARRY R. BADER

Mr. BEGICH. Mr. President, I wish congratulate Fairbanks, AK, resident Mr. Harry R. Bader for being the first Civilian Response Corps-Active Officer in the United States Agency for International Development, USAID, to be trained and ready for world-wide deployment.

Mr. Bader’s specialized training, which will allow him to work in high threat environments, was recognized by the Administrator of USAID in a November 23, 2009, ceremony in Washington, DC. Currently, Mr. Bader is the USAID Deputy Environmental Officer for the Democracy, Conflict and Humanitarian Assistance Bureau.

USAID’s Civilian Response Corps is a commendable program. The Corps plays an integral part in U.S. national security strategy. One of their missions is to bring military and civilian efforts in order to stabilize fragile states and to improve the effectiveness of counter-insurgency operations.

As an active officer, Mr. Bader’s environmental security specialty will be brought to bear in those areas of the developing world where scarcity or degradation of natural resource contribute to conflict. His task will be to find ways to reduce the means and motivations for violence.

Mr. Bader’s diverse educational and professional backgrounds make him well suited to excel as a Civilian Response Corps-Active Officer. He has a law degree from Harvard and B.A. from Washington State University. Mr. Bader has been a professor, author, researcher, lecturer, natural resource manager and consultant.

He taught at the University of Alaska Fairbanks as an associate professor of resources policy at the School of Natural Resources Management. During his tenure, he served on the Alaska Sea Grant Legal Research Team, which was created in response to the Exxon Valdez Oil Spill and which will allow him to work in high threat environments.

At the Alaska Department of Natural Resources, Mr. Bader was the northern region land manager in Fairbanks, where he was responsible for the stewardship of 40 million acres of public land in the arctic and boreal regions of Alaska. He often collaborated with industry and academia in developing land use policy.

Until recently, Mr. Bader was active with the End Talk Group, a consulting firm that specializes in resource management issues in challenging social and physical environments.

He travelled to Tajikistan, Iraq,
and Ukraine lending his expertise in the development of democracy and governance. Mr. Bader is also perusing a midcareer doctorate at the Yale School of Forestry and Environmental Studies.

I applaud Harry on this appointment and am confident he will make contributions to security and environmental improvement wherever he is assigned by the Corps.

TRIBUTE TO DONALD DOWD

Mr. KERRY. Mr. President, I congratulate Don Dowd for his lifetime public service to New England and to the Commonwealth of Massachusetts. For more than half a century Mr. Dowd has been a fixture in the culture, civic life, and politics of our region of the United States. I also congratulate one of the many organizations with which Mr. Dowd has been associated—Special Olympics Massachusetts, part of the international Special Olympics organized by Eunice Shriver in 1968.

Special Olympics Massachusetts has just moved into a new state-of-the-art office and training center in Marlborough. Special Olympics Training Center has training rooms, a gymnasium and outdoor soccer fields, all right in the heart of Massachusetts, less than a 90-minute drive from 90 percent of the population of the Commonwealth. Mr. Dowd has been one of the biggest friends to Senator Edward M. Kennedy throughout Ted’s entire 47-year career. Mr. Dowd has been associated—Special Olympics Massachusetts hopes to expand the program to 20,000 athletes by 2010. Mr. Dowd began his public service career as the Assistant Regional Director of the U.S. Postal Service for the six New England States during the Presidency of John F. Kennedy. He was political adviser to Robert F. Kennedy’s Presidential campaign in 1968. And he was an aide and close friend to Senator Edward M. Kennedy throughout Ted’s entire 47-year career in the Senate. Mr. Dowd coordinated the 1979 opening of the John F. Kennedy Library and Museum. He served as a member of the John F. Kennedy Library Foundation Board since its inception. Mr. Dowd continues to do consulting work since his retirement from his regional executive position with the Coca-Cola Company.

The newly merged business soon moved to downtown Orono’s Main Street and remained there until nearly 1960, when it relocated again to the company’s current location at 20 Water Street. The Tenney family retained ownership until about 1970 when the company underwent three short-lived transitions to new owners. The current proprietors, Steve and Nancy Holt, share the privilege of carrying forward the legacy of this unique novelty company. Since the Holts came aboard, they have expanded the company’s product line to include other specialty products such as masts, spars, boat hooks, and railings. At the same time, the Holts take pride in producing the same quality product that’s earned Shaw and Tenney their continued success in the future.

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mrs. Neiman, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

MESSAGES FROM THE HOUSE

At 12:33 p.m., a message from the House of Representatives, delivered by Mr. Cole, one of its yeoman clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 3029. An act to establish a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined cycle and simple cycle power generation systems.
H. R. 3508. An act to ensure consideration of water intensity in the Department of Energy’s energy research, development, and demonstration programs to help guarantee efficient, reliable, and sustainable delivery of energy and water resources.

H. R. 3667. An act to designate the facility of the United States Postal Service located at 16555 Springs Street in White Springs, Florida, as the “Clyde L. Hillhouse Post Office Building”.

ENROLLED BILLS SIGNED

At 2:54 p.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the Speaker has signed the following enrolled bills:

S. 1599. An act to amend title 36, United States Code, to include in the Federal charter of the Reserve Officers Association leadership positions newly added in its constitution and bylaws.

S. 1869. An act to permit each current member of the Board of Directors of the Office of Compliance to serve for 3 terms.

The enrolled bills were subsequently signed by the President pro tempore (Mr. BYRD).

At 3:12 p.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House has passed the following bill, without amendment:

S. 1422. An act to amend the Family and Medical Leave Act of 1993 to clarify the eligibility requirements with respect to airline flight crews.

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H. R. 3029. An act to establish a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined cycle power generation systems; to the Committee on Energy and Natural Resources.

H. R. 3508. An act to ensure consideration of water intensity in the Department of Energy’s energy research, development, and demonstration programs to help guarantee efficient, reliable, and sustainable delivery of energy and water resources; to the Committee on Energy and Natural Resources.

H. R. 3667. An act to designate the facility of the United States Postal Service located at 16555 Springs Street in White Springs, Florida as the “Clyde L. Hillhouse Post Office Building”; to the Committee on Homeland Security and Governmental Affairs.

ENROLLED BILLS PRESENTED

The Secretary of the Senate reported that on December 2, 2009, she had presented to the President of the United States, the following enrolled bills:

S. 1599. An act to amend title 36, United States Code, to include in the Federal charter of the Reserve Officers Association leadership positions newly added in its constitution and bylaws.

S. 1869. An act to permit each current member of the Board of Directors of the Office of Compliance to serve for 3 terms.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–3779. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, a rule entitled “Walnuts Grown in California; Increased Assessment Rate” (Docket No. AMS–FV–09–0063; FV09–966–2 IFR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3780. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, a rule entitled “Tomatoes Grown in Florida; Decreased Assessment Rate” (Docket No. AMS–FV–09–0054; FV09–959–2 IFR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3781. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled “Tomatoes Grown in Florida; Decreased Assessment Rate” (Docket No. AMS–FV–09–0054; FV09–959–2 IFR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3782. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled “Onions Grown in South Texas; Decreased Assessment Rate” (Docket No. AMS–FV–09–0044; FV09–959–2 IFR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3783. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled “Pistachios Grown in California; Order Amendment Staff, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled “Applications for Food and Drug Administration Approval to Market a New Drug; Postmarketing Reports; Reporting Information About Authorized Generic Drugs” (Docket No. FDA–2008–N–0341) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3784. A communication from the Deputy Director of Regulations and Policy Management Staff, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled “Listing of Color Additives Exempt From Certification; Paracoccid Pigment” (Docket No. FDA–2007–R–0037; CL 40–455) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Banking, Housing, and Urban Affairs.
EC–3796. A communication from the Secretary of the Treasury, transmitting, pursuant to law, a six-month period report on the national emergency with respect to Burma, in the Executive Report for fiscal year 2009, to the Committee on Energy and Natural Resources.

EC–3797. A communication from the Secretary of the Treasury, transmitting, pursuant to law, a six-month period report on the national emergency with respect to stabilization of Iraq that was declared in Executive Order 13303 of May 22, 2003, to the Committee on Banking, Housing, and Urban Affairs.

EC–3798. A communication from the Administrator and Chief Executive Officer, Bonneville Power Administration, Department of Energy, transmitting, pursuant to law, the 2008 Annual Report for fiscal year 2009, to the Committee on Energy and Natural Resources.

EC–3799. A communication from the Departmental Freedom of Information Officer, Office of the Secretary, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled “Amendment to the Presidential Permit Regulations” (RIN1090–AA61) as received during adjournment of the Senate in the Office of the President of the Senate on November 23, 2009, to the Committee on Environment and Public Works.

EC–3800. A communication from the Deputy Assistant Administrator for Regulatory Programs, Office of Regulations and Policy, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled “Electronic Payment and Refund of Quarterly Harbor Maintenance Fees” (RIN1505–A927) received in the Office of the President of the Senate on November 18, 2009, to the Committee on Finance.

EC–3801. A communication from the Chief of the Trade and Commercial Regulations Branch, Customs and Border Protection, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled “Emergency Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled “Amendments to the Presidential Permit Regulations” (RIN1090–AA61) as received during adjournment of the Senate in the Office of the President of the Senate on November 23, 2009, to the Committee on Environment and Public Works.

EC–3802. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled “Applicable Federal Rates—December 2009” (Rev. Rul. 2009–38) received in the Office of the President of the Senate on November 30, 2009, to the Committee on Finance.

EC–3803. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled “Agreements for Payment of Tax Liabilities in Installments” (RIN1545–AU97) received in the Office of the President of the Senate on November 30, 2009, to the Committee on Finance.

EC–3804. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled “Notice: Tier 2 Tax Rates for 2010” received in the Office of the President of the Senate on November 30, 2009, to the Committee on Finance.

EC–3805. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled “Notice Requirements for Certain Pension Plan Amendments Significantly Reducing the Rate of Future Benefits” (Treas. Reg. 26Q 19472) received in the Office of the President of the Senate on November 30, 2009, to the Committee on Finance.

EC–3806. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled “Agreements for the export of defense articles, including, technical data, and defense services to the United Arab Emirates relative to the design and manufacture of Commercial Communication Satellites” in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3807. A communication from the Chief of the Trade and Commercial Regulations Branch, Customs and Border Protection, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled “Amendment to the Presidential Permit Regulations” (RIN1090–AA61) as received during adjournment of the Senate in the Office of the President of the Senate on November 23, 2009, to the Committee on Environment and Public Works.

EC–3808. A communication from the Deputy Assistant Administrator for Regulatory Programs, Office of Regulations and Policy, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled “Emergency Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled “Amendments to the Presidential Permit Regulations” (RIN1090–AA61) as received during adjournment of the Senate in the Office of the President of the Senate on November 23, 2009, to the Committee on Environment and Public Works.

EC–3809. A communication from the Deputy Assistant Administrator for Regulatory Programs, Office of Regulations and Policy, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled “Emergency Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled “Amendments to the Presidential Permit Regulations” (RIN1090–AA61) as received during adjournment of the Senate in the Office of the President of the Senate on November 23, 2009, to the Committee on Environment and Public Works.

EC–3810. A communication from the Assistant Secretary, Office of Legislative Affairs, Department of State, transmitting, pursuant to law, the report of a rule entitled “Agreements for the export of defense articles, including, technical data, and defense services to the United Arab Emirates relative to the design and manufacture of Commercial Communication Satellites” in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3811. A communication from the Assistant Secretary, Office of Legislative Affairs, Department of State, transmitting, pursuant to law, the report of a rule entitled “Amendment to the Presidential Permit Regulations” (RIN1090–AA61) as received during adjournment of the Senate in the Office of the President of the Senate on November 23, 2009, to the Committee on Finance.

EC–3812. A communication from the Assistant Secretary, Office of Legislative Affairs, Department of State, transmitting, pursuant to law, the report of a rule entitled “Amendment to the Presidential Permit Regulations” (RIN1090–AA61) as received during adjournment of the Senate in the Office of the President of the Senate on November 23, 2009, to the Committee on Finance.

EC–3813. A communication from the Assistant Secretary, Office of Legislative Affairs, Department of State, transmitting, pursuant to law, the report of a rule entitled “Amendment to the Presidential Permit Regulations” (RIN1090–AA61) as received during adjournment of the Senate in the Office of the President of the Senate on November 23, 2009, to the Committee on Finance.

EC–3814. A communication from the Assistant Secretary, Office of Legislative Affairs, Department of State, transmitting, pursuant to law, the report of a rule entitled “Amendment to the Presidential Permit Regulations” (RIN1090–AA61) as received during adjournment of the Senate in the Office of the President of the Senate on November 23, 2009, to the Committee on Finance.

EC–3815. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to law, the report of a rule entitled “Agreements for the export of defense articles, including, technical data, and defense services to the United Arab Emirates relative to the design and manufacture of Commercial Communication Satellites” in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3816. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to law, the report of a rule entitled “Agreements for the export of defense articles, including, technical data, and defense services to the United Arab Emirates relative to the design and manufacture of Commercial Communication Satellites” in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3817. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to law, the report of a rule entitled “Agreements for the export of defense articles, including, technical data, and defense services to the United Arab Emirates relative to the design and manufacture of Commercial Communication Satellites” in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3818. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to law, the report of a rule entitled “Agreements for the export of defense articles, including, technical data, and defense services to the United Arab Emirates relative to the design and manufacture of Commercial Communication Satellites” in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3819. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to law, the report of a rule entitled “Agreements for the export of defense articles, including, technical data, and defense services to the United Arab Emirates relative to the design and manufacture of Commercial Communication Satellites” in the amount of $50,000,000 or more; to the Committee on Foreign Relations.
EC–3823. A communication from the Deputy Assistant Secretary for Program Operation, Employee Benefits Security Administration, Department of Labor, transmitting, pursuant to law, a report entitled “Investment Advice—Participants and Beneficiaries—Withdrawal of Final Rule” (RIN2101–AB13) as received during adjournment of the Senate on November 24, 2009; to the Committee on Health, Education, Labor, and Pensions.

EC–3824. A communication from the Chief Human Capital Officer, Corporation for National and Community Service, transmitting, pursuant to law, the report of a rule entitled “Investment Advice—Participants and Beneficiaries—Withdrawal of Final Rule” (RIN2101–AB13) as received in the Office of the President of the Senate on November 18, 2009; to the Committee on Health, Education, Labor, and Pensions.

EC–3825. A communication from the Assistant General Counsel for Regulatory Services, Office of Elementary and Secondary Education, Department of Education, transmitting, pursuant to law, the report of a rule entitled “Race to the Top Fund—Final Priorities” (RIN1810–AA07) received in the Office of the President of the Senate on November 19, 2009; to the Committee on Health, Education, Labor, and Pensions.

EC–3826. A communication from the Assistant Secretary, Employment and Training Administration, Department of Labor, transmitting, pursuant to law, the report of a rule entitled “Operating Instructions for Implementing the Amendments to the Trade Act of 1974 Enacted by the Trade and Globalization Adjustment Act of 2009” (TEGL No. 22–08) received in the Office of the President of the Senate on November 19, 2009; to the Committee on Health, Education, Labor, and Pensions.

EC–3827. A communication from the Secretary of the Interior, transmitting, pursuant to law, the Office of Inspector General’s Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3828. A communication from the Chairman, Office of Inspector General’s Semiannual Report for Fiscal Year 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3829. A communication from the Acting Chief Financial Officer, Department of Homeland Security, transmitting, pursuant to law, the Office of Inspector General’s Semiannual Report to Congress for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3830. A communication from the Director, National Science Foundation, transmitting, pursuant to law, the URL address for the Agency’s Financial Report, Annual Performance Report, and Performance Highlights Report; to the Committee on Homeland Security and Governmental Affairs.

EC–3831. A communication from the President, Federal Financing Bank, transmitting, pursuant to law, the Bank’s Annual Report for Fiscal Year 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3832. A communication from the Chairman, Merit System Protection Board, transmitting, pursuant to law, a report entitled “As Supervisors Retire: An Opportunity to Reshape in Ways that Work”; to the Committee on Homeland Security and Governmental Affairs.

EC–3833. A communication from the Chairman, Merit System Protection Board, transmitting, pursuant to law, the Commission’s Fiscal Year 2009 Agency Financial Report; to the Committee on Homeland Security and Governmental Affairs.

EC–3834. A communication from the Board Members, Railroad Retirement Board, transmitting, pursuant to law, a report entitled “Railroad Retirement Board’s Performance and Accountability Report for Fiscal Year 2009”; to the Committee on Homeland Security and Governmental Affairs.

EC–3835. A communication from the Secretary of Veterans Affairs, transmitting, pursuant to law, the Office of Inspector General’s Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3836. A communication from the Chairman, Railroad Retirement Board, transmitting, pursuant to law, the Office of Inspector General’s Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3837. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, the Department of Health and Human Services Office of Inspector General’s Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3838. A communication from the Administrator, General Services Administration, transmitting, pursuant to law, the report of a rule entitled “Final Rule and Explanation and Justification for Campaign Travel” (No. 1205–19) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Rules and Administration.

EC–3839. A communication from the Acting Deputy General Counsel, Office of Policy and Strategic Planning, Small Business Administration, transmitting, pursuant to law, the report of a rule entitled “Temporary Agricultural Employment of H–2A Aliens in the United States” (RIN2410–AD46) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on the Judiciary.

EC–3840. A communication from the Department of State, transmitting, pursuant to law, a report relative to the transfer of detainees (OSSS Control No. 2009–1964); to the Committee on the Judiciary.

EC–3841. A communication from the Department of State, transmitting, pursuant to law, a report relative to the transfer of detainees (OSSS Control No. 2009–1964); to the Committee on the Judiciary.

EC–3842. A communication from the Chairman, Office of Inspector General’s Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3843. A communication from the Director, National Aeronautics and Space Administration, transmitting, pursuant to law, the report of a rule entitled “Patents and Other Intellectual Property Rights” (RIN7000–AD46) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3844. A communication from the Chairman of the National Transportation Safety Board, transmitting, pursuant to law, a report relative to the transfer of detainees (OSSS Control No. 2009–1964); to the Committee on Commerce, Science, and Transportation.

EC–3845. A communication from the Assistant Secretary of the Employment and Training Administration, Department of Labor, transmitting, pursuant to law, the report of a rule entitled “Temporary Agricultural Employment of H–2A Aliens in the United States” (RIN2410–AD46) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on the Judiciary.

EC–3846. A communication from the Department of State, transmitting, pursuant to law, a report relative to the transfer of detainees (OSSS Control No. 2009–1964); to the Committee on the Judiciary.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of nominations were submitted:

By Mr. LEVIN for the Committee on Armed Services.

S12159

December 2, 2009

CONGRESSIONAL RECORD — SENATE

EXECUTIVE REPORTS OF COMMITTEES
Army nomination of Robert J. Schultz, to be Lieutenant Colonel. Army nominations beginning with Clement D. Ketchum and ending with John Lopez, which nominations were received by the Senate and appeared in the Congressional Record on November 4, 2009. Army nominations beginning with Carey L. Mitchell and ending with Melissa F. Dickerson, which nominations were received by the Senate and appeared in the Congressional Record on November 4, 2009. Army nominations beginning with Craig R. Bottomi and ending with Akash S. Taggarise, which nominations were received by the Senate and appeared in the Congressional Record on November 4, 2009. Army nominations beginning with Leon L. Robert, to be Colonel. Army nomination of Michael C. Metcalf, to be Colonel. Army nominations beginning with Todd E. Farmer and ending with Steven R. Watt, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009. Army nominations beginning with Mark D. Crowley and ending with Michael J. Stevenson, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009. Army nominations beginning with Nathaniel L. Allen and ending with X001320, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009. Army nominations beginning with Scott C. Armstrong and ending with D004309, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009. Army nominations beginning with Michael W. Anastasia and ending with D003756, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009. Army nominations beginning with Scott E. McNeil, to be Colonel. Army nomination of Scott E. Zipprich, to be Colonel. Army nomination of Mary B. McQuary, to be Colonel. Army nominations beginning with Marvin R. Manibusan and ending with Francisco J. Serrano, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009. Army nominations beginning with Patrick S. Callis and ending with Steven L. Shugart, which nominations were received by the Senate and appeared in the Congressional Record on November 17, 2009. Army nominations beginning with Michael A. Bennett and ending with Kevin M. Walker, which nominations were received by the Senate and appeared in the Congressional Record on November 17, 2009. Army nominations beginning with Timothy M. Sherry and ending with Robert N. Mills, which nominations were received by the Senate and appeared in the Congressional Record on November 17, 2009. Army nominations beginning with Thomas B. Sutton and ending with Stacy M. Wuthier, which nominations were received by the Senate and appeared in the Congressional Record on November 17, 2009. *Nomination was reported with recommendation that it be confirmed subject to the nominee’s commitment to respond to requests to appear and testify before any duly constituted committee of the Senate. (Nominations without an asterisk were reported with the recommendation that they be confirmed.)

**INTRODUCTION OF BILLS AND JOINT RESOLUTIONS**

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

- By Mr. MENENDEZ:
  - S. 2822. A bill to amend chapter 417 of title 49, United States Code, to require air carriers and ticket agents to notify consumers of all taxes and fees applicable to airline tickets in a timely manner, to prohibit the imposition of fuel surcharges that do not correlate to the fuel costs incurred by air carriers, and for other purposes; to the Committee on Commerce, Science, and Transportation.
  - S. 2824. A bill to establish a small dollar loan-loss guarantee fund, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

**SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS**

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

- By Mrs. MURRAY (for herself and Ms. CANTWELL):
  - S. 366. A resolution extending condolences to the families of Sergeant Mark Ruhminger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards; considered and agreed to.

**ADDITIONAL COSPONSORS**

- S. 435. At the request of Mr. CASEY, the name of the Senator from Vermont (Mr. SANDERS) was added as a cosponsor of S. 435, a bill to provide for evidence-based and promising practices related to juvenile delinquency and criminal street gang activity prevention and intervention to help build individual, family, and community strength and resiliency to ensure that youth lead productive, safe, health, gang-free, and law-abiding lives.

- S. 497. At the request of Mr. WEBB, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 491, a bill to amend the Internal Revenue Code of 1986 to allow Federal civilian and military retirees to pay health insurance premiums on a pre-tax basis and to allow a deduction for TRICARE supplemental premiums.

- S. 497. At the request of Mr. DURBIN, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 497, a bill to reauthorize the Public Health Service Act to authorize capitation grants to increase the number of nursing faculty and students, and for other purposes.
At the request of Mr. Brown, the name of the Senator from Pennsylvania (Mr. Casey) was added as a cosponsor of S. 777, a bill to promote industry growth and competitiveness and to improve worker training, retention, and advancement, and for other purposes.

S. 890
At the request of Mr. Kerry, the name of the Senator from Vermont (Mr. Leahy) was added as a cosponsor of S. 890, a bill to amend the High Seas Driftnet Fishing Moratorium Protection Act and the Magnuson-Stevens Fishery Conservation and Management Act to improve the conservation of sharks.

S. 1019
At the request of Mr. Harkin, the name of the Senator from Michigan (Ms. Stabenow) was added as a cosponsor of S. 1019, a bill to amend the Internal Revenue Code of 1986 to allow a credit against income tax for the purchase of hearing aids.

S. 1052
At the request of Mr. Conrad, the name of the Senator from Minnesota (Mr. Franken) was added as a cosponsor of S. 1052, a bill to amend the small, rural school achievement program and the rural and low-income school program under part B of title VI of the Elementary and Secondary Education Act of 1965.

S. 1304
At the request of Mr. Grassley, the name of the Senator from Louisiana (Mr. Vitter) was added as a cosponsor of S. 1304, a bill to restore the economic rights of automobile dealers, and for other purposes.

S. 1353
At the request of Mr. Leahy, the name of the Senator from New York (Mr. Schumer) was added as a cosponsor of S. 1353, a bill to amend title I of the Omnibus Crime Control and Safe Streets Act of 1986 to include nonprofit and volunteer ground and air ambulance crew members and first responders for certain benefits.

S. 1368
At the request of Mr. Brown, the name of the Senator from Pennsylvania (Mr. Casey) was added as a cosponsor of S. 1368, a bill to permit Amtrak passengers to safely transport firearms and ammunition in their checked baggage.

S. 1744
At the request of Mr. Schumer, the name of the Senator from Maine (Ms. Sowle) was added as a cosponsor of S. 1744, a bill to require the Administrator of the Federal Aviation Administration to prescribe regulations to ensure that all crewmembers on air carriers have proper qualifications and experience, and for other purposes.

S. 1822
At the request of Mr. Merkley, the names of the Senator from Arkansas (Mr. Pryor) and the Senator from Michigan (Ms. Stabenow) were added as cosponsors of S. 1822, a bill to amend the Emergency Economic Stabilization Act of 2008, with respect to considerations of the Secretary of the Treasury in providing assistance under that Act, and for other purposes.

S. 1839
At the request of Mr. Rockefeller, the name of the Senator from Pennsylvania (Mr. Casey) was added as a cosponsor of S. 1839, a bill to reinstate Federal matching of State spending of child support incentive payments.

S. 1997
At the request of Mr. Thune, the names of the Senator from Oklahoma (Mr. Inhofe) and the Senator from West Virginia (Mr. Byrd) were added as cosponsors of S. 1997, a bill to authorize the redefinition of Columbia War Memorial as a National and District of Columbia World War I Memorial to honor the sacrifices made by American veterans of World War I.

S. 2128
At the request of Mr. LeMieux, the name of the Senator from Nebraska (Mr. Johanns) was added as a cosponsor of S. 2128, a bill to provide for the establishment of the Office of Deputy Secretary for Health Care Fraud Prevention.

S. 2277
At the request of Mr. Lugar, the name of the Senator from Minnesota (Mr. Franken) was added as a cosponsor of S. 2277, a bill to provide for continued application of arrangements under the Protocol on Inspections and Continuous Monitoring Activities relating to the Treaty Between the United States of America and the Union of Soviet Socialist Republics on the Reduction and Limitation of Strategic Offensive Arms in the period following the Protocol’s termination on December 5, 2009.

S. 2370
At the request of Mr. Brown, the names of the Senator from Illinois (Mr. Durbin), the Senator from Vermont (Mr. Sanders), the Senator from Michigan (Mr. Levin) and the Senator from New Jersey (Mr. Lautenberg) were added as cosponsors of S. 2370, a bill to extend and enhance the COBRA subsidy program under the American Recovery and Reinvestment Act of 2009.

S. 2781
At the request of Ms. Mikulski, the name of the Senator from Nebraska (Mr. Johanns) was added as a cosponsor of S. 2781, a bill to change references in Federal law to mental retardation to references to an intellectual disability, and to change references to a mentally retarded individual to references to an individual with an intellectual disability.

S. 2794
At the request of Mr. Schumer, the name of the Senator from Nebraska (Mr. Neufeld) was added as a cosponsor of S. 2794, a bill to amend the Internal Revenue Code of 1986 to provide tax incentives for the donation of wild game meat.

S. 3212
At the request of Mr. Bingaman, the name of the Senator from Arizona (Mr. Jon Kyl) was added as a cosponsor of S. 3212, a bill to amend the Energy Policy Act of 2005 to require the Secretary of Energy to carry out programs to develop and demonstrate 2 small modular nuclear reactor designs, and for other purposes.

S. CON. RES. 39
At the request of Mr. Menendez, the name of the Senator from New Jersey (Mr. Lautenberg) was added as a cosponsor of S. Con. Res. 39, a concurrent resolution expressing the sense of the Congress that stable and affordable housing is an essential component of an effective strategy for the prevention, treatment, and care of human immunodeficiency virus, and that the United States should make a commitment to providing adequate funding for the development of housing as a response to the acquired immunodeficiency syndrome pandemic.

AMENDMENT NO. 2790
At the request of Mr. Casey, the name of the Senator from Minnesota (Mr. Franken) was added as a cosponsor of amendment No. 2790 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first—time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2791
At the request of Ms. Mikulski, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of amendment No. 2791 proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first—time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2793
At the request of Mr. Dorgan, the names of the Senator from Vermont (Mr. Sanders) and the Senator from Minnesota (Mr. Franken) were added as cosponsors of amendment No. 2793 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first—time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2795
At the request of Mr. Leahy, the names of the Senator from Illinois (Mr.
DURBIN) and the Senator from Louisiana (Ms. LANDRIEU) were added as cosponsors of amendment No. 2795 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. KOHL (for himself and Mr. DURBIN):

S. 2824. A bill to establish a small dollar loan-loss guarantee fund, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

Mr. KOHL. Mr. President, I rise to introduce the Safe Affordable Loan Act. This legislation will increase the access for low and moderate income Americans to mainstream financial institutions while reducing the relevance of payday lenders. Additionally, the bill will encourage community banks and credit unions to provide small dollar loan amounts to families across their communities.

There are approximately 30 million Americans operating on the fringe of the financial system. They are known as the “unbanked.” The average income for these individuals is approximately $25,000, with little to no savings. Additionally, these consumers rely on check cashing services or payday lenders as a way to access credit. Most of these operations charge excessive fees and interest rates that leave consumers financially devastated. Without access to mainstream financial services, consumers can be trapped in a cycle of debt with little hope of escape.

In 2008, the FDIC launched a Small Dollar Loan program, which offers volunteer participants CRA credit to provide consumers with affordable small dollar loans. I am proud that two banks from Wisconsin, Mitchell Bank in Milwaukee and Benton State Bank in Benton are participating in this valuable program. While this program has been beneficial to communities across the country, only 31 banks have chosen to participate. That is a drop in the bucket compared to the 23,000 payday lender operations. Without other incentives for banks and other financial institutions, it is unlikely that we can increase access for consumers by providing them small dollar loans.

The legislation I am proposing would create a loan-loss reserve fund that financial institutions could access in order to mitigate some of the risk associated with offering small dollar loans. Financial institutions will be able to access the reserve fund and could potentially recover 60 percent of a lost loan, provided that their loans meet certain requirements. The institutions must offer loans that have no prepayment penalties, have a repayment period longer than 60 days and have an interest rate of 36 percent APR or lower. Additionally, the loan size cannot exceed $2,500. In order to protect the government from excessive risk taking by the financial institutions, the fund administrator will take into consideration the overall default rate of the loan program. The institution offers to determine the reimbursement rate. Furthermore, the financial institutions would be required to report payment history to the credit reporting bureaus which will help consumers build credit or repair bad credit.

As we consider changes to our financial system, we should include reforms that will help increase access to many of those who are left out. I look forward to working with my colleagues on this important issue in the Banking Committee to move it towards passage.

AMENDMENTS SUBMITTED & PROPOSED

SA 2798. Mr. INOUYE submitted an amendment intended to be proposed to amendment SA 2796 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 2800. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2796 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, super; which was ordered to lie on the table.

SA 2802. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2796 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, super; which was ordered to lie on the table.

SA 2803. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2796 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, super; which was ordered to lie on the table.

SA 2804. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2796 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, super; which was ordered to lie on the table.

SA 2805. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2796 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, super; which was ordered to lie on the table.

SA 2806. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2796 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, super; which was ordered to lie on the table.

SA 2807. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2796 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, super; which was ordered to lie on the table.

SA 2808. Mr. VITTER submitted an amendment intended to be proposed to amendment SA 2791 proposed by Ms. MIKULSKI (for herself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, super; which was ordered to lie on the table.
SA 2809. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2810. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2811. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2812. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2813. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2814. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2815. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2816. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2817. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2818. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2819. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2820. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2821. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2822. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2823. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2824. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2825. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2826. Mr. BENNET (for himself, Mr. HARKIN, Mr. MURKOWSKI, Mr. BURHIS, and Mr. WYDEN) submitted an amendment in lieu of amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2827. Mr. TESTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2828. Mr. WHITEHOUSE (for himself, Mr. MURKOWSKI, Mr. HARKIN, Mr. FEINGOLD, and Mr. FRANKEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2829. Ms. MURKOWSKI (for herself, Mr. ROYbal-Allard, Mr. JOHANNS, Mr. STEINBERGER, Mr. BAYH, and Mrs. SHAHEEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2830. Mr. BROWNBACK (for himself and Mr. LAUTENBERG) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2831. Mr. JOHANNES submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2832. Mr. JOHANNES submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2833. Mr. JOHANNES submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2834. Mr. JOHANNES submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2835. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.
amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2853. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2854. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2855. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2857. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2859. Ms. SNOWE (for herself, Ms. LANDRIEU, and Mrs. LINCOLN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2798. Mr. INOUYE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Reid (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle D of title V, add the following:

SEC. 5106. DEMONSTRATION GRANTS FOR FAMILY NURSE PRACTITIONER TRAINING PROGRAMS.

(a) Establishment of Program.—The Secretary of Health and Human Services (referred to in this section as the ‘‘Secretary’’) shall establish a training demonstration program for family nurse practitioners (referred to in this section as the ‘‘program’’) to employ and provide intensive, one-year training for nurse practitioners who have graduated from a nurse practitioner program not more than three years prior to commencing such training, for careers as primary care providers in Federally qualified health centers (referred to in this section as ‘‘FQHCs’’) and nurse-managed health clinics, in order to increase access to primary care in impoverished, urban, and rural underserved communities.

(b) Purpose.—The purpose of the program is to enable each grant recipient to—

(1) provide nurse practitioners with a depth, breadth, volume, and intensity of clinical training necessary to serve as primary care providers in the complex settings of FQHCs and nurse-managed health clinics;

(2) train new nurse practitioners to work under a model of primary care, including the use of electronic health records, planned care and chronic illness, and interdisciplinary team-based care, that is consistent with—

(A) the principles of health care set forth by the Institute of Medicine; and

(B) the needs of vulnerable populations;

(3) create a model of FQHC- and nurse-managed health clinic-based training for nurse practitioners that may be replicated nationwide;

(4) provide additional intensive learning experiences with high-volume, high-risk, or high-burden populations encountered in FQHCs and nurse-managed health clinics, such as HIV/AIDS, prenatal care, orthopedics, geriatrics, diabetes, asthma, and obesity prevention.

(c) Grants.—The Secretary shall award grants to eligible entities that meet the eligibility requirements established by the Secretary for operating the nurse practitioner primary care programs described in subsection (a) in such entities.

(d) Eligible Entities.—To be eligible to receive a grant under this section, an entity shall—

(1) (A) be a FQHC as defined in section 180(b)(5) of the Social Security Act (42 U.S.C. 1395x(aa)); or

(B) be a nurse-managed health clinic, as defined in section 350a-1 of the Public Health Service Act (as added by section 5206 of this Act); and

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(e) Priority in Awarding Grants.—In awarding grants under this section, the Secretary shall give priority to eligible entities that—

(1) demonstrate sufficient infrastructure in size, scope, and capacity to undertake the requisite training of a minimum of 3 nurse practitioners per year and the half-time employment of a qualified program coordinator;

(2) will contract such program with an entity that will entail 12-1/2 months of full-time, paid employment for each awardee, and will offer each awardee benefits consistent with the benefits offered to other full-time employees of such entity;

(3) will assign not less than 1 staff nurse practitioner or physician to each of 4 rotations consisting of 3 sessions per week, either within or outside of the FQHC or nurse-managed health clinic, based upon the capability of the FQHC or nurse-managed health clinic to provide specialty or substitute training in prenatal care and women’s health, adult and child psychiatry, orthopedics, geriatrics, and at least 3 other high-volume, high-burden specialty areas, such as HIV/AIDS, mental health, cardiology, cardiology, diabetes, asthma, urgent care (minor trauma), and pain management;

(4) provide to each awardee specialty rotations consisting of 3 sessions per week either within or outside of the FQHC or nurse-managed health clinic, based upon the capability of the FQHC or nurse-managed health clinic to provide specialty or substitute training in prenatal care and women’s health, adult and child psychiatry, orthopedics, geriatrics, and at least 3 other high-volume, high-burden specialty areas, such as HIV/AIDS, mental health, cardiology, cardiology, diabetes, asthma, urgent care (minor trauma), and pain management;

(5) enable awardees to practice alongside other primary care providers so that the awardees may consult with such primary care providers as necessary;

(6) provide continuous training and didactic sessions on high-volume, high-risk health problems;

(7) have implemented (or will complete, not later than the commencement of the program, the implementation of) health information technology, and will make use of an electronic training evaluation system;

(8) provide continuous training to a FQHC standard of a high performance health system that includes access to health care, continuity, planned care, team-based, prevented care, care coordination, and the use of electronic health records and other health information technology;

(9) have a record of recruiting, training, caring for, and otherwise demonstrating competency in advising the primary care of individuals who are from underrepresented minority groups or from a poor urban, or otherwise disadvantaged background;

(10) have a record of training health care professionals in the care of vulnerable populations, such as children, homeless, individuals with mental health or substance-related disorders, individuals with HIV/AIDS, and individuals with disabilities; and

(11) have a record of collaboration with other safety net providers, schools, colleges, and universities that provide health professionals training, establish formal relationships, and submit joint applications with rural health clinics, area health education centers, and community health centers located in underserved areas, or that serve underserved populations.

(f) Eligibility of Awardees.—

(1) In General.—To be eligible for acceptance as a nurse practitioner training program funded through a grant awarded under this section, an individual shall—

(A) be licensed or eligible for licensure in the State in which the program is located as an advanced practice registered nurse or advanced practice nurse and be eligible or board-certified as a family nurse practitioner; and

(B) demonstrate commitment to a career as a primary care provider in a FQHC or in a nurse-managed health clinic.

(2) Preference.—In awarding grants under this section, the Secretary shall give priority to awardees under the program, each recipient of a grant under this section shall give preference to bilingual candidates that meet the requirements described in this section, and individuals who are from underrepresented racial or ethnic minorities who have a record of recruiting, training, caring for, and otherwise demonstrating competency in advising the primary care of individuals who are from underrepresented minority groups or from poor urban, or otherwise disadvantaged background.

(3) Deferral of Certain Service.—The starting date of required service of individuals in the National Health Service Corps program, and the duration of service of individuals in the FQHC or nurse-managed health clinic, shall be deferred until the date that is 90 days after the completion of the program.

(4) Awardee Defined.—In this section, the term ‘‘awardee’’ means an individual who has been accepted into a nurse practitioner training program funded through a grant awarded under this section.

(g) Duration of Awards.—Each grant awarded under this section shall be for a period of 3 years. A grant recipient may carry over funds from one fiscal year to another without obtaining approval from the Secretary.

(h) Grant Amount.—Each grant awarded under this section shall be in an amount not to exceed $750,000 per year, as determined by the Secretary, taking into account—

(1) the financial need of the FQHC or nurse-managed health clinic, considering, Federal, State, local, and other operational
funding provided to the FQHC or nurse-managed health clinic; and
(2) other factors, as the Secretary determines appropriate.

(1) TECHNICAL ASSISTANCE GRANTS.—The Secretary may award technical assistance grants to FQHCs and nurse-managed health clinics that plan to establish, or that have established, a nurse practitioner residency training program. The Secretary shall award a technical assistance grant to 1 FQHC that has expertise in establishing a nurse practitioner residency program, for the purpose of providing technical assistance to other recipients of grants under this section.

(2) AUTHORIZATION OF APPROPRIATIONS.—To carry out paragraph (1) there shall be appropriated such sums as may be necessary for each of fiscal years 2011 through 2014.

SA 2799. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. 1. ENTITLEMENT REFORM.

Notwithstanding any other provision of this Act (or an amendment made by this Act), this Act (and amendments), other than this section, shall not take effect until such time as the Office of the Actuary for the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) would result in an estimated budgetary savings to the Federal budget in 2018 as a result of the implementation of this Act (and amendments).

SA 2800. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to modify the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. 1. LOWERING COSTS FOR FAMILIES.

Notwithstanding any other provision of this Act (or an amendment made by this Act), this Act (and amendments), other than this section, shall not take effect until such time as the Office of the Actuary for the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) would reduce the Federal budgetary commitment to health care by January 1, 2019, as compared to Federal budgetary commitment to health care by January 1, 2019, that would have resulted if such Act (and amendments) is not implemented.

SA 2801. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. 1. ENSURING LOWER HEALTH CARE COSTS.

Notwithstanding any other provision of this Act (or an amendment made by this Act), this Act (and amendments), other than this section, shall not take effect until such time as the Office of the Actuary for the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) would reduce the Federal budgetary commitment to health care by January 1, 2019, as compared to Federal budgetary commitment to health care by January 1, 2019, that would have resulted if such Act (and amendments) is not implemented.

SA 2802. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. 1. REQUIREMENT OF ELIMINATION OF THE FEDERAL DEFICIT.

Notwithstanding any other provision of this Act (or an amendment made by this Act), no Federal outlays authorized under this Act (or such an amendment) may take effect until the Office of Management and Budget certifies that the Federal budget deficit has been eliminated.

SA 2806. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to modify the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. 1. INELIGIBLE FOR FEHB.

Effective January 1, 2010, no Member of Congress shall be eligible to obtain health insurance coverage under the program chapter 89 of title 5, United States Code.

SA 2804. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. Harkin) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

SEC. 2008. NONAPPLICATION OF MEDICAID ELIGIBILITY EXPANSIONS UNTIL REDUCTION IN MEDICAID FRAUD RATE.

Notwithstanding any other provision of this Act, any provision of this Act or an amendment made by this Act that imposes federally-mandated expansions of eligibility for Medicaid shall not apply to any State before the date on which the Secretary of Health and Human Services certifies that the average payment error rate measure (commonly referred to as "PERM") for all State Medicaid programs does not exceed 3.9 percent.

SA 2805. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. 1. REQUIREMENT OF ELIMINATION OF THE FEDERAL DEFICIT.

Notwithstanding any other provision of this Act (or an amendment made by this Act), no Federal outlays authorized under this Act (or such an amendment) may take effect until the Office of Management and Budget certifies that the Federal budget deficit has been eliminated.

SA 2803. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. 1. REQUIREMENT OF ELIMINATION OF THE FEDERAL DEFICIT.

Notwithstanding any other provision of this Act (or an amendment made by this Act), no Federal outlays authorized under this Act (or such an amendment) may take effect until the Office of Management and Budget certifies that the Federal budget deficit has been eliminated.
time as the Office of the Actuary for the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) would reduce projected National Health Expenditures by January 1, 2019, as compared to the projected National Health Expenditures by January 1, 2019 for the following Internal Revenue Act (and amendments) is not implemented.

SA 2807. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1000, strike line 19 and all that follows through line 2 on page 1053.

SA 2808. Mr. VITTER submitted an amendment intended to be proposed to amendment SA 2791 proposed by Ms. MIKULSKI, Mr. CORNYN, Mr. BOXER, and Mr. FRANKEN to the amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2 of the amendment, after line 15 insert the following:

"(5) for the purposes of this Act, and for the purposes of any other provisions of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009."

SA 2809. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

"(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with childhood cancer."

SA 2811. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

"(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with autism."

SA 2812. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 842, strike line 3 and all that follows through page 846, line 10.

SA 2813. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 923, between lines 7 and 8, insert the following:

"SEC. 2011. PROTECTING CHOICE AND COMPETITION FOR MEDICARE BENEFICIARIES.

No provisions of amendments made by this Act that change the Medicare Advantage program under part C of title XVIII of the Social Security Act in a manner that would result in decreased choice and competition for Medicare beneficiaries shall take effect and are repealed."

SA 2814. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

"(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with chronic obstructive pulmonary disease (COPD)."

SA 2815. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

"(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with cancer."

SA 2817. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 826, strike line 5 and all that follows through page 836, line 22.

SA 2818. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

"(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with juvenile diabetes.

S12166
SA 2819. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 974, strike line 12 and all that follows through page 999, line 16.

SA 2820. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1000, strike line 19 and all that follows through page 1008, line 9.

SA 2821. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 889, strike line 17 and all that follows through page 903, line 15.

SA 2822. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1000, strike line 19 and all that follows through page 1083, line 2.

SA 2823. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 2006.

SA 2824. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1203, strike line 19 and all that follows through page 1209, line 20 and insert the following:

SEC. 4201. COMMUNITY TRANSFORMATION GRANTS.

(a) In General.—The Secretary of Health and Human Services shall award competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of chronic diseases, reduce health disparities, and develop stronger evidence-base of effective prevention programming, with not less than 20 percent of such grants being made to State or local government agencies and community-based organizations located in or serving, or both, rural areas.

(b) Eligibility.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be a State governmental agency;

(2) a local governmental agency;

(3) a national network of community-based organizations;

(4) a State or local non-profit organization; or

(5) an Indian tribe.

(c) Use of Funds.—

(1) In General.—An eligible entity shall use amounts received under a grant under this section to carry out the program described in this subsection.

(2) Community Transformation Plan.—(A) In General.—An eligible entity that receives a grant under this section shall submit to the Director a detailed plan that includes the evidence-base of effective prevention programming, appropriate infrastructure changes needed to promote healthy living and reduce disparities, and activities to prevent chronic diseases.

(B) Activities.—Activities within the plan may focus on (but not be limited to)—

(i) creating healthier school environments, including increasing physical activity opportunities, promoting healthy lifestyle, emotional wellness, and prevention curricula, and activities to prevent chronic diseases.

(ii) creating the infrastructure to support active living and access to nutritious foods in a safe environment.

(iii) developing and promoting programs targeting a variety of age levels to increase access to nutrition, physical activity and smoking cessation, improve social and emotional wellness, enhance safety in a community, or address any other chronic disease priority area identified by the grantee.

(iv) assessing and implementing worksite wellness programming.

(v) working to highlight healthy options at restaurants and other food venues;
(vi) prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health; and
(vii) addressing special populations needs, including all age groups and individuals with disabilities, and individuals in both urban, rural, and frontier areas.

(3) COMMUNITY-BASED PREVENTION HEALTH ACTIVITIES.—

(A) In general.—An eligible entity shall use amounts received under a grant under this section to implement a variety of programs, policies, and infrastructure improvements to promote healthier lifestyles.

(B) Activities.—An eligible entity shall implement a single detailed in the community transformation plan under paragraph (2).

(C) In-kind support.—An eligible entity may provide in-kind resources such as staff, equipment, or office space in carrying out activities under this section.

(4) Evaluation.—

(A) In general.—An eligible entity shall use amounts provided under a grant under this section to conduct activities to measure changes in the prevalence of chronic disease risk factors in the community members partici-pating in preventive health activities.

(B) Types of measures.—In carrying out subparagraph (A), the eligible entity shall, with respect to residents in the community, measure—

(i) changes in weight;
(ii) changes in proper nutrition;
(iii) changes in physical activity;
(iv) changes in tobacco use prevalence;
(v) changes in emotional well-being and overall mental health;
(vi) other factors using community-specific data from the Behavioral Risk Factor Surveillance Survey; and
(vii) other factors as determined by the Secretary, including, differential susceptibility, mortality, or morbidity due to chronic diseases such as cancer, diabetes, and cardiovascular disease.

(C) Reporting.—An eligible entity shall annually submit to the Director a report containing an evaluation of activities carried out under the grant.

(5) Dissemination.—A grantee under this section shall—

(A) at least annually in regional or national forums, including conferences, best practices, and lessons learned with respect to activities carried out under the grant; and
(B) develop model for the replication of successful programs and activities and the mentoring of other eligible entities.

(d) Training.—

(1) In general.—The Director shall develop a program to provide training for eligible entities on effective strategies for the prevention and control of chronic disease and the link between physical, emotional, and social well-being.

(2) Community transformation plan.—The Director shall provide appropriate feedback and technical assistance to grantees to establish community transformation plans.

(e) Evaluation.—The Director shall provide a literature review and framework for the evaluation of programs conducted as part of the grant program under this section, in addition to working with academic institutions or other entities with expertise in outcome evaluation.

(f) Prohibition.—A grantee shall not use funds provided under a grant under this section to create video games or to carry out any other activities that may lead to higher rates of obesity or inactivity.

(i) Authorization of appropriations.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each fiscal years 2010 through 2014.

SEC. 2401A. REDUCTION OF HEALTH DISPARITIES IN RURAL AREAS.

(a) Authorization of initiative.—

(1) In general.—The Secretary of Health and Human Services, in collaboration or con-junction with the Director of the National Cancer Institute and the Assistant Secretary for Minority Health, shall establish an initiative.

(A) That is specifically directed toward ad-dressing health disparities attributable to chronic diseases in rural and frontier areas by creating and promoting educational, screening, and outreach pro-grams that reduce morbidity, mortality, and mortality of chronic diseases or suscetibility to such diseases; and

(B) whose goal is to significantly improve access to, and utilization of, beneficial chronic disease interventions in rural communities experiencing health disparities in order to reduce such disparities.

(2) Health disparity population.—

(A) In general.—For purposes of carrying out the initiative described in paragraph (1), a population shall be considered a health disparity population if the health disparity is a significant disparity in the overall rate of chronic disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general popu-lation.

(B) Chronic diseases.—In this paragraph, the term "chronic disease" includes hypertension, diabetes, cancer, and heart disease.

(c) Common administrative structure.—

The initiative described in subsection (a) shall—

(1) utilize a common administrative struc-ture to ensure coordinated implementation, oversight, and accountability;

(2) be amenable to regional organization in order to meet the specific needs of rural communities throughout the United States; and

(3) involve elements located in rural communities and areas.

(d) Design.—The initiative described in subsection (a) shall be designed to reach rural communities and populations that experience a disproportionate share of chronic disease burden, including African Americans, American Indians or Alaska Natives, Hawaiians, other Pacific Islanders, Asians, Hispanics or Latinos, and other underserved rural populations.

(e) Establishment of initiative and grants.—The initiative described in subsection (a), the Secretary of Health and Human Services shall, from funds appropriated to carry out this section—

(1) use 50 percent for the establishment of such initiative; and

(2) use 50 percent to award competitive grants or contracts to organizations, universities, or similar entities to carry out the initiative, with preference given to entities having a demonstrable track record of serv-ice to rural communities, including tribally-affiliated colleges and universities.

SA 2828. MR. WHITEHOUSE (for himself, MR. KERRY, MR. FEINGOLD, and MR. FRANKEN) submitted an amendment ininserting after the bill H.R. 3590, to amend the Internal Revenue code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. 4. DISMISSAL OF A CASE OR CONVERSION TO A CASE UNDER CHAPTER 11 OR 13.

Section 707(b) of title 11, the United States Code, is amended by adding at the end the following:

"(2) CONFORMING AMENDMENTS.—Sections 104(b)(1) and 104(b)(2) of title 11, the United States Code, are each amended by inserting "$250,000" after "$250,000", as applicable."
‘‘(8) No judge, United States trustee (or bankruptcy administrator, if any), trustee, or other party in interest may file a motion under paragraph (2) if the debtor is a medically distressed debtor in accordance with the amendment intended to be proposed to title 11, United States Code, on or after the date of enactment of this Act.

Section 109(h)(4) of title 11 United States Code, is amended by inserting ‘‘a medically distressed debtor’’ after ‘‘or, with respect to’’.

SEC. 6. NONDISCHARGEABILITY OF CERTAIN ATTORNEYS FEES.

Section 523(a) of title 11, United States Code, is amended—

(1) in paragraph (18), by striking ‘‘or’’ at the end;—

(2) in paragraph (19), by striking the period at the end and inserting ‘‘; and’’;—

(3) by inserting after paragraph (19) the following:

‘‘(20) in a case arising under chapter 7 of this title, owed to an attorney as reasonable compensation for representing the debtor in connection with the case.’’.

SEC. 7. EFFECTIVE DATE; APPLICATION OF AMENDMENTS.

(a) EFFECTIVE DATE.—Except as provided in subsection (b), this title and the amendments made by this title shall take effect on the date of enactment of this Act.

(b) APPLICATION OF AMENDMENTS.—The amendments made by this title shall apply only with respect to cases commenced under title 11, United States Code, on or after the date of enactment of this Act.

SEC. 8. ATTESTATION BY DEBTOR.

Any debtor who seeks relief as a medically distressed debtor in accordance with the amendments made by this title shall attest in writing and under penalty of perjury that the medical expenses of the debtor were genuine, and were not specifically incurred to bring the debtor within the coverage of the medical bankruptcy provisions, as provided in this title and the amendments made by this title.

SA 2829. Mr. GRAHAM (for himself and Mr. CHAMBLISS) submitted an amendment intended to be proposed to amendment SA 2796 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyer credit and the home mortgage interest deduction in the case of the armed forces and certain other Federal employees, and for other purposes; which was ordered to lie on the calendar; as follows:

At the appropriate place, insert the following:

TITLE —MEDICAL LIABILITY REFORM

SEC. 01. SHORT TITLE.

This title may be cited as the ‘‘Fair Resolution of Medical Liability Disputes Act of 2009’’.

SEC. 02. FINDINGS.

Congress finds that—

(1) the health care and insurance industries are industries affecting interstate commerce, and the health care malpractice litigation systems throughout the United States affect interstate commerce by contributing to the high cost of health care and premiums for malpractice insurance purchased by health care providers; and

(2) the Federal Government, as a direct provider of health care and as a source of payment for health care, has a major interest in health care and a demonstrated interest in assessing the quality of care, access to care, and the costs of care through the evaluative activities of several Federal agencies.

SEC. 03. DEFINITIONS.

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ‘‘alternative dispute resolution system’’ or ‘‘ADR’’ means a system established under this title that provides for the resolution of health care malpractice claims in a manner other than through a civil action in Federal or State court.

(2) COVERED HEALTH CARE MALPRACTICE ACTION.—The term ‘‘covered health care malpractice action’’ means a civil action in which a covered health care malpractice claim is made by a health care provider or health care professional.

(3) COVERED HEALTH CARE MALPRACTICE CLAIM.—The term ‘‘covered health care malpractice claim’’ means a malpractice claim (excluding product liability claims) relating to the provision of, or the failure to provide, health care services in connection with a covered health care provider or provider.

(4) COVERED HEALTH CARE PROFESSIONAL.—The term ‘‘covered health care professional’’ means an individual, including a physician, nurse, chiropractor, nurse midwife, physical therapist, social worker, or physician assistant—

(A) who provides health care services in a State;

(B) for whom individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), or enrolled for benefits under part B of such Act (42 U.S.C. 1395b et seq.) comprise not less than 25 percent of the total patients of such professional, as determined by the Secretary; and

(C) who is required by State law or regulation to be licensed or certified by a State as a condition for providing such services in the State.

(5) COVERED HEALTH CARE PROVIDER.—The term ‘‘covered health care provider’’ means an organization or institution—

(A) that is engaged in the delivery of health care services in a State;

(B) for which individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), or enrolled for benefits under part B of such Act (42 U.S.C. 1395p et seq.) comprise not less than 25 percent of the total patients of such organization or institution, as determined by the Secretary; and

(C) that is required by State law or regulation to be licensed or certified by the State as a condition for engaging in the delivery of such services in the State.

(6) Secretary.—The term ‘‘Secretary’’ means the Secretary of Health and Human Services.

(7) STATE.—The term ‘‘State’’ means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

SEC. 04. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—A covered health care malpractice action may not be brought in any State court during a calendar year unless the covered health care malpractice claim that is the subject of the action has been initially resolved under an alternative dispute resolution system described in paragraph (1) that applied in the State whose law applies in such action.

(b) APPLICATION TO COVERED HEALTH CARE MALPRACTICE CLAIMS.—A covered health care malpractice claim under an alternative dispute resolution system, that the judgment or order obtained is not more favorable to the party contesting the ADR decision than the ADR decision, the opposing party may file with the court, not later than 10 days after the final judgment or order is issued, a petition for payment of costs and expenses, including attorneys’ fees, incurred after judgment or trial in the action is not more favorable to a party contesting the ADR decision than the ADR decision, the opposing party may file with the court a claim for attorneys’ fees incurred after judgment or trial in the action is not more favorable to a party contesting the ADR decision than the ADR decision, the opposing party may file with the court a claim for attorneys’ fees incurred after judgment or trial in the action is not more favorable to a party contesting the ADR decision than the ADR decision.

(c) IN GENERAL.—A covered health care malpractice action may not be brought in a Federal court under section 1332 of title 28, United States Code, during a calendar year unless the covered health care malpractice claim that is the subject of the action has been initially resolved under the alternative dispute resolution system described in paragraph (1) that applied in the State whose law applies in such action.

(d) APPLICATION TO COVERED HEALTH CARE MALPRACTICE CLAIMS.—A covered health care malpractice claim under an alternative dispute resolution system, that the judgment or order obtained is not more favorable to the party contesting the ADR decision than the ADR decision, the opposing party may file with the court a claim for attorneys’ fees incurred after judgment or trial in the action is not more favorable to a party contesting the ADR decision than the ADR decision.

SEC. 05. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—A covered health care malpractice action may not be brought in any State court during a calendar year unless the covered health care malpractice claim that is the subject of the action has been initially resolved under an alternative dispute resolution system described in paragraph (1) that applied in the State whose law applies in such action.

(b) APPLICATION TO COVERED HEALTH CARE MALPRACTICE CLAIMS.—A covered health care malpractice claim under an alternative dispute resolution system, that the judgment or order obtained is not more favorable to the party contesting the ADR decision than the ADR decision, the opposing party may file with the court a claim for attorneys’ fees incurred after judgment or trial in the action is not more favorable to a party contesting the ADR decision than the ADR decision.

(c) IN GENERAL.—A covered health care malpractice action may not be brought in a Federal court under section 1332 of title 28, United States Code, during a calendar year unless the covered health care malpractice claim that is the subject of the action has been initially resolved under the alternative dispute resolution system described in paragraph (1) that applied in the State whose law applies in such action.

(d) APPLICATION TO COVERED HEALTH CARE MALPRACTICE CLAIMS.—A covered health care malpractice claim under an alternative dispute resolution system, that the judgment or order obtained is not more favorable to the party contesting the ADR decision than the ADR decision, the opposing party may file with the court a claim for attorneys’ fees incurred after judgment or trial in the action is not more favorable to a party contesting the ADR decision than the ADR decision.

SEC. 06. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—A covered health care malpractice action may not be brought in any State court during a calendar year unless the covered health care malpractice claim that is the subject of the action has been initially resolved under an alternative dispute resolution system described in paragraph (1) that applied in the State whose law applies in such action.

(b) APPLICATION TO COVERED HEALTH CARE MALPRACTICE CLAIMS.—A covered health care malpractice claim under an alternative dispute resolution system, that the judgment or order obtained is not more favorable to the party contesting the ADR decision than the ADR decision, the opposing party may file with the court a claim for attorneys’ fees incurred after judgment or trial in the action is not more favorable to a party contesting the ADR decision than the ADR decision.

(c) IN GENERAL.—A covered health care malpractice action may not be brought in a Federal court under section 1332 of title 28, United States Code, during a calendar year unless the covered health care malpractice claim that is the subject of the action has been initially resolved under the alternative dispute resolution system described in paragraph (1) that applied in the State whose law applies in such action.
contesting the ADR decision with respect to
the claim or claims the ADR decision,
the court shall order the contesting party
to pay the costs and expenses of the opposing
party, including attorneys’ fees, incurred
with respect to the claim or claims after the
date of the ADR decision, unless the court
finds that requiring the payment of such
costs and expenses would be manifestly un-
just.

(3) LIMITATION.—Attorneys’ fees awarded
under this subsection shall be in an amount
reasonably attributable to the claim or
claims involved, calculated on the basis of
an hourly rate of the attorney, which may not
exceed that which the court considers
an hourly rate of the attorney, which may
be higher than the fees charged by the
attorney to other clients, if the court deter-
mines that the attorney’s fees charged by
the attorney to other clients were not
reasonably attributable to the claim or
claims involved.

(4) BASIS FOR CERTIFICATION.—The
Attorney General shall certify the alternative
dispute resolution system of a State under
this subsection for a calendar year if the
Attorney General determines under paragraph (1)
that such system meets the requirements of
section 05.

(a) CERTIFICATION.—
(1) IN GENERAL.—Not later than 270 days
after the date of enactment of this Act and
periodically thereafter, the Attorney Gen-
eral, in consultation with the Secretary,
determine whether the alternative dis-
pute resolution systems of each State meet
the requirements of this title.

(b) EFFECTIVE DATE.—Notwithstanding any
other provision of this title, or of any
amendment made by this title—
(1) no reference in this title, or in such
amendments, to the date of enactment of
this title shall be deemed to be a reference to
the date of enactment of this Act and
the amendments made by this title;

(2) each reference to “January 1, 2012” in
section 10006(c) shall be substituted with “90
days after the effective date of this title”.

SEC. 05. BASIC REQUIREMENTS FOR STATE AL-
TERNATIVE DISPUTE RESOLUTION
SYSTEMS.

The alternative dispute resolution system
of a State meets the requirements of this
section if the system—

(1) applies to all covered health care mal-
practice claims under the jurisdiction of
the courts of such State;

(2) requires that a written opinion resolv-
ing the dispute be issued not later than 180
days after the date on which each party
agrees to the procedure for resolving such
claim;

(3) requires an appropriate assessment of the
costs incurred by the parties to a dispute;

(4) applies to medical malpractice claims;

(5) permits the parties to a dispute to se-
lect the procedure to be used for the resolu-
tion of the dispute, assigns a particular proce-
dure to each party, and provides for the
transmittal to the State agency responsible
for monitoring or disciplining professionals
and health care providers of any findings made
under the system that such an attorney or
provider committed malpractice, unless,
during the pendency of a case where the
system resolves the claim against the
professional or provider, the professional or
provider brings an action contesting the deci-
sion made under the system; and

(6) provides for the regular transmission to
the State agency responsible for monitoring
or disciplining professionals and health care
providers of all information on the parties
and the complexity of the case. Attorneys’
fees incurred under this subsection may not exceed
that which the court considers
an hourly rate of the attorney, which may
be higher than the fees charged by the
attorney to other clients, if the court deter-
mines that the attorney’s fees charged by
the attorney to other clients were not
reasonably attributable to the claim or
claims involved.

(7) LIMITATION.—Attorneys’ fees awarded
under this subsection shall be in an amount
reasonably attributable to the claim or
claims involved, calculated on the basis of
an hourly rate of the attorney, which may
be higher than the fees charged by the
attorney to other clients, if the court deter-
mines that the attorney’s fees charged by
the attorney to other clients were not
reasonably attributable to the claim or
claims involved.

(b) APPLICABILITY OF ALTERNATIVE
FEDERAL SYSTEM.

(1) ESTABLISHMENT AND APPLICABILITY.—
Not later than 270 days after the date of en-
actment of this Act, the Attorney General,
with the concurrence of the Secretary, shall
establish by rulemaking an alternative Federal
ADR system for the resolution of cov-
ered health care malpractice claims during a
calendar year in States that do not have an alter-
native dispute resolution system that is certified
under subsection (a) for such year.

(2) REQUIREMENTS.—Under the alternative
Federal ADR system established under paragraph (1)

(a) paragraphs (1), (2), (6), and (7) of section
303 shall apply to claims brought under such
system;

(b) the claims brought under such system
shall be heard and resolved by medical and
legal experts appointed as arbitrators by the
Attorney General, in consultation with the
Secretary;

(c) with respect to a State in which such
system is in effect, the Attorney General
may (at the request of such State) modify
the system to take into account the exist-
ence of dispute resolution procedures in the
State that address resolution of health care
malpractice claims.

(d) LIMITATION.—Attorneys’ fees incurred
under this subsection shall be in an amount
reasonably attributable to the claim or
claims involved, calculated on the basis of
an hourly rate of the attorney, which may
be higher than the fees charged by the
attorney to other clients, if the court deter-
mimes that the attorney’s fees charged by
the attorney to other clients were not
reasonably attributable to the claim or
claims involved.

(3) TREATMENT OF STATES WITH AL-
TERNATIVE SYSTEM IN EFFECT.—If the
alternative Federal ADR system established under
this subsection is applied with respect to a State
for a calendar year such State shall reim-
burse the United States, at such time and in
such manner as the Secretary may require,
for the costs incurred by the United States
during such year as a result of the applica-
tion of the system with respect to the State.

SEC. 07. GOAL OF PRIVATE LITIGATION INSURANCE.

The Comptroller General of the United
States shall—

(1) undertake a study of the effectiveness
of private litigation insurance markets, such as
those in the United Kingdom and Ger-
many, in providing affordable access to
courts, evaluating the merit of prospective
claims, and ensuring that prevailing parties in
“loser pays” systems are reimbursed for
attorneys’ fees; and

(2) not later than 270 days after the date of
enactment of this Act, submit to Congress a
report describing the results of such study.

SEC. 2008. NONAPPLICATION OF ANY MEDICAID
ELIGIBILITY EXPANSION UNIl T REDUCTION IN MEDICAID FRAUD RATE.

Notwithstanding any other provision of
this Act, with respect to a State, any provi-
sion of this Act or an amendment made by
this Act that imposes a federally-mandated
expansion of eligibility for Medicaid shall
not apply to the State before the date on
which the State Medicaid Director certifies
to the Secretary of Health and Human Serv-
ices that the Medicaid payment error rate
measurement (commonly referred to as
“error rate”) for the State does not exceed 5
percent.

SEC. 2832. Mr. JOHANNS submitted an
amendment intended to be proposed to
amendment SA 2786 proposed by Mr.
REID (for himself, Mr. BAUCUS, Mr.
DODD, and Mr. HARKIN) to the bill H.R.
3590, to amend the Internal Revenue
Code of 1986 to modify the first-time
homebuyers credit in the case of mem-
bers of the Armed Forces and certain
other Federal employees, and for other
purposes; which was ordered to lie on
the table; as follows:

On page 204 of the amendment, after line 7,
add the following:

SEC. 10011. CERTIFICATION.

(a) IN GENERAL.—This title (other than this
section), and the amendments made by this
title—

(1) pose no additional risk to the public’s
health and safety; and

(2) result in a significant reduction in the
overall costs of covered products to the American
consumer.

(b) EFFECTIVE DATE.—Notwithstanding any
other provision of this title, or of any
amendment made by this title—

(1) any reference in this title, or in such
amendments, to the date of enactment of
this title shall be deemed to be a reference to
the date of enactment of this Act;

(2) each reference to “January 1, 2012” in
section 10006(c) shall be substituted with “90
days after the effective date of this title”.

SEC. 2833. Mr. JOHANNS submitted an
amendment intended to be proposed to
amendment SA 2786 proposed by Mr.
REID (for himself, Mr. BAUCUS, Mr.
DODD, and Mr. HARKIN) to the bill H.R.
3590, to amend the Internal Revenue
Code of 1986 to modify the first-time
homebuyers credit in the case of mem-
bers of the Armed Forces and certain
other Federal employees, and for other
purposes; which was ordered to lie on
the table; as follows:

On page 2074, after line 25, add the fol-
lowing:
SEC. 2008. NONAPPLICATION OF ANY MEDICAID ELIGIBILITY EXPANSION UNTIL ENROLLMENT OF AT LEAST 90 PERCENT OF CURRENTLY ELIGIBLE INDIVIDUALS.

Notwithstanding any other provision of this Act, with respect to a State, any provision of this Act or an amendment made by this Act that imposes a federally-mandated expansion of eligibility for Medicaid shall not apply to Medicaid, to the extent that such expansion is in effect on the date on which the State Medicaid Director certifies to the Secretary of Health and Human Services that at least 90 percent of the individuals entitled to medical assistance under the State’s Medicaid plan, including under any waiver of such plan, are enrolled in the plan or waiver.

SA 2834. Mr. JOHANNES submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 340, between lines 21 and 22, insert the following:

(j) FLEXIBLE SPENDING ARRANGEMENTS.—The terms ‘‘health flexible spending arrangement’’ means any arrangement or a dependent care flexible spending arrangement solely because under the plan or arrangement a participant is permitted access to any unused balance in the participant’s accounts under such plan or arrangement in the manner provided under paragraph (2).

(k) DISTRIBUTION UPON TERMINATION.—

‘‘(1) DISTRIBUTION OF REMAINING BALANCES IN FLEXIBLE SPENDING ARRANGEMENTS UPON TERMINATION FROM EMPLOYMENT.—

‘‘(i) In general.—Section 129, respectively.’’.

‘‘(ii) Health flexible spending arrangements and dependent care flexible spending arrangements are subject to the requirements of section 129 of the Internal Revenue Code of 1986, respectively.’’.

The amendment has the following effects:

- Expanded eligibility for Medicaid
- Modified the first-time homebuyers credit
- Enhanced flexibility in spending arrangements
Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1, strike line 6 and all the following to the end and insert the following:

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

TITLE I—AMERICAN HEALTH SECURITY
Sec. 1002. Universal entitlement.
Sec. 1003. Qualifications for providers.

Subtitle B—Comprehensive Benefits, Including Preventive Benefits and Benefits for Long-Term Care
Sec. 1101. Special rules for home and community-based long-term care services.
Sec. 1102. Definitions relating to services.
Sec. 1103. Exclusions and limitations.

PART I—GENERAL ADMINISTRATIVE PROVISIONS
Sec. 1201. Provider participation and standards.
Sec. 1202. Qualifications for providers.
Sec. 1203. Exemptions.
Sec. 1204. Limitation on certain physician referrals.

PART II—CONTROL OVER FRAUD AND ABUSE
Sec. 1311. Application of Federal sanctions to all fraud and abuse under American Health Security Program.
Sec. 1312. Federal and State health fraud control activities.

TITLE II—PAYMENTS BY STATES TO PROVIDERS
Sec. 1510. Payments to hospitals and other facility-based services for operating expenses on the basis of approved global budgets.
Sec. 1511. Payments to health care practitioners based on prospective fee schedules.
Sec. 1512. Payments to comprehensive health service organizations.
Sec. 1513. Payments for community-based primary health services.
Sec. 1514. Payments for prescription drugs.
Sec. 1515. Payments for approved devices and equipment.
Sec. 1516. Payments for other items and services.
Sec. 1517. Payment incentives for medically underserved areas.
Sec. 1518. Amendments to alternative payment methodologies.

PART III—MANDATORY ASSIGNMENT AND ADMINISTRATIVE PROVISIONS
Sec. 1520. Mandatory assignment.
Sec. 1521. Procedures for reimbursement; appeals.

TITLE III—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH
Subtitle A—Modernizing Disease Prevention and Public Health Systems
Sec. 1602. Authority for alternative payment incentives.
Sec. 1603. Prohibition of employee benefits.

TITLE IV—HEALTH CARE WORKFORCE
Sec. 4001. Purpose.
Sec. 4002. Definitions.
Sec. 4003. National health care workforce commission.
Sec. 4004. Health care workforce development grants.
Sec. 4005. Health care workforce assessment.
Subtitle C—Increasing Access to Clinical Preventive Services
Sec. 3161. School-based health centers.
Sec. 3162. Oral healthcare prevention activities.

PART I—AMERICAN HEALTH SECURITY TRUST
Sec. 1511. Payments to health care practitioners.
Sec. 1512. Payments to health care practitioners.
Sec. 1513. Payments to health care practitioners.
Sec. 1514. Payments to health care practitioners.
Sec. 1515. Payments to health care practitioners.
Sec. 1516. Payments to health care practitioners.

PART II—TRUST FUNDS
Sec. 1517. Payments to health care practitioners.
Sec. 1518. Payments to health care practitioners.
Sec. 1519. Payments to health care practitioners.

PART III—MANDATORY ASSIGNMENT AND ADMINISTRATIVE PROVISIONS
Sec. 1520. Mandatory assignment.
Sec. 1521. Procedures for reimbursement; appeals.

PART IV—HEALTH CARE WORKFORCE
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Subtitle C—Increasing Access to Clinical Preventive Services
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Sec. 1515. Payments to health care practitioners.
Sec. 1516. Payments to health care practitioners.

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Subtitle C—Increasing Access to Clinical Preventive Services
Sec. 3161. School-based health centers.
Sec. 3162. Oral healthcare prevention activities.
Sec. 4603. Reauthorization of the Wakefield Workforce Education and Training

Sec. 4602. Negotiated rulemaking for developing the Wakefield Workforce Education and Training.

Sec. 4601. Spending for Federally Qualified Health Centers (FQHCs).

Sec. 4503. Graduate nurse education demonstration.

Sec. 4502. Increasing teaching capacity.

Sec. 4501. Centers of excellence.

Sec. 4404. Co-locating primary and specialty care in community-based mental health settings.

Sec. 4403. Graduate nurse education demonstration.

Sec. 4402. Health care professionals training for diversity.

Sec. 4401. Interdisciplinary, community-based linkages.

Sec. 4400. Workplace diversity grants.

Sec. 4310. Loan repayment and scholarship programs.

Sec. 4309. Nurse education, practice, and retention grants.

Sec. 4308. Advanced nursing education grants.

Sec. 4307. Cultural competency, prevention, and public health stakeholders.

Sec. 4306. Alternative dental health care providers demonstration project.

Sec. 4305. Geriatric education and training.

Sec. 4304. Alternative dental health care providers demonstration project.

Sec. 4303. Geriatric education and training; career awards; comprehensive educational programs.

Sec. 4302. Increasing teaching capacity.

Sec. 4301. Nurse education, practice, and retention grants.

Sec. 4208. Nurse-managed health clinics.

Sec. 4207. Introduction of the State-Based American Health Security Program; Universal Entitlement; Enrollment

Sec. 5104. Standardized complaint form.

Sec. 5103. Other health care workers.

Sec. 5102. Training in general, pediatric, and public health dentistry.

Sec. 5101. Required disclosure of ownership interests.

Sec. 5011. Skilled nursing facilities and providers.

Sec. 5010. Nurse education, practice, and retention grants.

Sec. 5009. Nurse education, practice, and retention grants.

Sec. 5008. Advanced nursing education grants.

Sec. 5007. Cultural competency, prevention, and public health stakeholders.

Sec. 5006. Cultural competency, prevention, and public health stakeholders.

Sec. 5005. Cultural competency, prevention, and public health stakeholders.

Sec. 5004. Cultural competency, prevention, and public health stakeholders.

Sec. 5003. Cultural competency, prevention, and public health stakeholders.

Sec. 5002. Cultural competency, prevention, and public health stakeholders.

Sec. 5001. Cultural competency, prevention, and public health stakeholders.

Sec. 5000. Cultural competency, prevention, and public health stakeholders.

Sec. 4901. Centers of excellence.

Sec. 4803. Graduate nurse education demonstration.

Sec. 4802. Increasing teaching capacity.

Sec. 4801. Centers of excellence.

Sec. 4703. Graduate nurse education demonstration.

Sec. 4702. Increasing teaching capacity.

Sec. 4701. Centers of excellence.

Sec. 4604. Co-locating primary and specialty care in community-based mental health settings.

Sec. 4505. Skilled nursing facilities and providers.

Sec. 4504. Skilled nursing facilities and providers.

Sec. 4503. Skilled nursing facilities and providers.

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Sec. 4402. Skilled nursing facilities and providers.

Sec. 4401. Skilled nursing facilities and providers.

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Sec. 4302. Skilled nursing facilities and providers.

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Sec. 4208. Skilled nursing facilities and providers.

Sec. 4108. Skilled nursing facilities and providers.

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Sec. 3908. Skilled nursing facilities and providers.

Sec. 3808. Skilled nursing facilities and providers.

Sec. 3708. Skilled nursing facilities and providers.

Sec. 3608. Skilled nursing facilities and providers.

Sec. 3508. Skilled nursing facilities and providers.

Sec. 3408. Skilled nursing facilities and providers.

Sec. 3308. Skilled nursing facilities and providers.

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Sec. 3008. Skilled nursing facilities and providers.

Sec. 2908. Skilled nursing facilities and providers.

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Sec. 2208. Skilled nursing facilities and providers.

Sec. 2108. Skilled nursing facilities and providers.

Sec. 2008. Skilled nursing facilities and providers.

Sec. 1908. Skilled nursing facilities and providers.

Sec. 1808. Skilled nursing facilities and providers.

Sec. 1708. Skilled nursing facilities and providers.

Sec. 1608. Skilled nursing facilities and providers.

Sec. 1508. Skilled nursing facilities and providers.

Sec. 1408. Skilled nursing facilities and providers.

Sec. 1308. Skilled nursing facilities and providers.

Sec. 1208. Skilled nursing facilities and providers.

Sec. 1108. Skilled nursing facilities and providers.

Sec. 1008. Skilled nursing facilities and providers.

Sec. 908. Skilled nursing facilities and providers.

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Sec. 708. Skilled nursing facilities and providers.

Sec. 608. Skilled nursing facilities and providers.

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Sec. 68. Skilled nursing facilities and providers.

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Sec. 48. Skilled nursing facilities and providers.

Sec. 38. Skilled nursing facilities and providers.

Sec. 28. Skilled nursing facilities and providers.

Sec. 18. Skilled nursing facilities and providers.

Sec. 8. Skilled nursing facilities and providers.

Sec. 7. Skilled nursing facilities and providers.

Sec. 6. Skilled nursing facilities and providers.

Sec. 5. Skilled nursing facilities and providers.

Sec. 4. Skilled nursing facilities and providers.

Sec. 3. Skilled nursing facilities and providers.

Sec. 2. Skilled nursing facilities and providers.

Sec. 1. Skilled nursing facilities and providers.
resident alien” means an alien lawfully admitted for permanent residence and any other alien lawfully residing permanently in the United States under color of law, including an alien with lawful temporary resident status under section 210, 210A, or 215A of the Immigration and Nationality Act (8 U.S.C. 1100, 1101, or 1255a).

SEC. 1002. ENROLLMENT.

(a) IN GENERAL.—Each State health security program shall provide a mechanism for the enrollment of individuals entitled or eligible for benefits under this title. The mechanism shall—

(1) include a process for the automatic enrollment of individuals at the time of birth in the United States and at the time of immigration into the United States or other acquisition of lawful resident status in the United States;

(2) provide for the enrollment, as of January 1, 2011, of all individuals who are eligible to be enrolled as of such date; and

(3) include a process for the enrollment of individuals made eligible for health care services under subsections (b) and (c) of section 1002.

(b) AVAILABILITY OF APPLICATIONS.—Each State health security program shall provide applications for enrollment under the program available—

(1) at employment and payroll offices of employers located in the State;

(2) at local offices of the Social Security Administration;

(3) at social services locations;

(4) at outreach sites (such as provider and practitioner locations); and

(5) at other locations (including post offices and schools) accessible to a broad cross-section of individuals eligible to enroll.

(c) ISSUANCE OF HEALTH SECURITY CARDS.—In conjunction with an individual’s enrollment for benefits under this title, the State health security program shall provide for the issuance of a health security card that shall be used for purposes of identification and processing of claims for benefits under the program. The State health security program may provide for issuance of such cards by employers for purposes of carrying out enrollment pursuant to subsection (a)(2).

SEC. 1003. ENROLLMENT.

(a) IN GENERAL.—To ensure continuous access to benefits for health care services covered under this title, each State health security program shall—

(1) shall not impose any minimum period of residence in the State, or waiting period, in excess of 3 months before residents of the State are entitled to, or eligible for, such benefits;

(b) AVAILABILITY OF APPLICATIONS.—Each State health security program shall provide an application for enrollment pursuant to subsection (a)(2).

(c) ISSUANCE OF HEALTH SECURITY CARDS.—In conjunction with an individual’s enrollment for benefits under this title, the State health security program shall provide for the issuance of a health security card that shall be used for purposes of identification and processing of claims for benefits under the program. The State health security program may provide for issuance of such cards by employers for purposes of carrying out enrollment pursuant to subsection (a)(2).

(d) PORTABILITY OF BENEFITS.

SEC. 1004. PORTABILITY OF BENEFITS.

(a) IN GENERAL.—To ensure continuous access to benefits for health care services covered under this title, each State health security program shall—

(1) shall not impose any minimum period of residence in the State, or waiting period, in excess of 3 months before residents of the State are entitled to, or eligible for, such benefits; and

(2) provide for the enrollment of individuals made eligible for health care services under subsections (b) and (c) of section 1002.

(b) AVAILABILITY OF APPLICATIONS.—Each State health security program shall provide applications for enrollment under the program available—

(1) at employment and payroll offices of employers located in the State;

(2) at local offices of the Social Security Administration;

(3) at social services locations;

(4) at outreach sites (such as provider and practitioner locations); and

(5) at other locations (including post offices and schools) accessible to a broad cross-section of individuals eligible to enroll.

(c) ISSUANCE OF HEALTH SECURITY CARDS.—In conjunction with an individual’s enrollment for benefits under this title, the State health security program shall provide for the issuance of a health security card that shall be used for purposes of identification and processing of claims for benefits under the program. The State health security program may provide for issuance of such cards by employers for purposes of carrying out enrollment pursuant to subsection (a)(2).

SEC. 1005. EFFECTIVE DATE OF BENEFITS.

(a) IN GENERAL.—Notwithstanding any other provision of law, subject to paragraph (2)—

(A) no benefits shall be available under title XVIII of the Social Security Act for any item or service furnished after December 31, 2010;

(B) no individual is entitled to medical assistance under a State plan approved under title XVIII of such Act for any item or service furnished after such date;

(C) no individual is entitled to medical assistance under an SCHIP plan under title XXI of such Act for any item or service furnished after such date; and

(D) no payment shall be made to a State under section 1903(a) or 2105(a) of such Act with respect to medical assistance or child health assistance for any item or service furnished after such date.

(b) TRANSITION.—In the case of inpatient hospital services and extended care services furnished during a continuous period of stay which began before January 1, 2011, and which had not ended as of such date, for which benefits are provided under a State plan under title XIX, or a State child health plan under title XXI, of the Social Security Act, the Secretary of Health and Human Services and each State plan, respectively, shall provide for continuation of benefits under such title or plan until the end of the period of stay.

(c) B EFER TO EXISTING FEDERAL BENEFITS.—Nothing in this title shall affect the eligibility of veterans for benefits under title XIX, or a State plan under title XXI, for any item or service furnished after December 31, 2010.

(d) B EFER TO EXISTING FEDERAL BENEFITS.—Nothing in this title shall affect the eligibility of veterans for benefits under title XIX, or a State plan under title XXI, for any item or service furnished after December 31, 2010.

(e) B EFER TO EXISTING FEDERAL BENEFITS.—Nothing in this title shall affect the eligibility of veterans for benefits under title XIX, or a State plan under title XXI, for any item or service furnished after December 31, 2010.

(f) B EFER TO EXISTING FEDERAL BENEFITS.—Nothing in this title shall affect the eligibility of veterans for benefits under title XIX, or a State plan under title XXI, for any item or service furnished after December 31, 2010.
Disabilities Education Act for services furnished pursuant to a written Individualized Family Services Plan or Individual Education Plan under such Act; and (g) the specific services furnished, at least once every 5 years, in consultation with experts in preventive medicine and public health.

(b) Periodic screening mammography, Pap smears, and color-rectal examinations and examinations for prostate cancer.

(c) Physical examinations.

(d) Family planning services.

(e) Routine eye examinations, eyeglasses, and contact lenses.

(f) Hearing aids, but only upon a determination of a certified audiologist or physician that a hearing problem exists and is caused by a condition that can be corrected by use of a hearing aid.

(3) Schedule.—The Board shall establish, in consultation with experts in preventive medicine and public health and taking into consideration those preventive services recommended by the Preventive Services Task Force and published as the Guide to Clinical Preventive Services, a periodicity schedule for the coverage of preventive services under paragraph (1). Such schedule shall take into consideration the cost-effectiveness of appropriate preventive care and shall be revised not less than once every 5 years, in consultation with experts in preventive medicine and public health.

(c) Home and Community-Based Long-Term Care Services.—In this title, the term “home and community-based long-term care services” means the following services provided to an individual to enable the individual to remain in such individual’s place of residence within the community:

(1) Home health aide services.

(2) Adult day health care, social day care or psychiatric day care.

(3) Medical social work services.

(4) Care coordination services, as defined in subsection (a)."
forth the physician’s diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan, but does not include any item or service that is not furnished in accordance with standards established by the Secretary for the management of such services.

(b) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are—

(1) partial hospitalization services consisting of the items and services described in subparagraph (C);

(2) psychiatric rehabilitation services;

(iii) day treatment services for individuals under 19 years of age;

(4) in-home services;

(v) case management services, including collaboration with the Board, the State, or other professional organizations or agencies which the State health status program determines—

(i) is capable of performing directly, efficiently, and effectively the duties of a care coordinator described in paragraph (1); and

(ii) demonstrates capability in establishing and periodically reviewing and revising plans of care and in monitoring the quality and quality of services under any plan.

(B) INDEPENDENCE.—State health status programs shall establish safeguards to assure that care coordinators have no financial interest in treatment decisions or placements.

(iii) case management services, including assisting patients in identifying and gaining access to appropriate ancillary services;

(iv) evaluating and recommending appropriate types of services, in cooperation with patients and other providers, and in conjunction with any quality review program or plan of care review.

(2) CARE COORDINATOR.—

(A) IN GENERAL.—In this title, the term ‘care coordinator’ means an individual or nonprofit, voluntary, or public agency or organization which the State health status program determines—

(i) is capable of performing directly, efficiently, and effectively the duties of a care coordinator described in paragraph (1); and

(ii) demonstrates capability in establishing and periodically reviewing and revising plans of care and in monitoring the provision and quality of services under any plan.

(B) INDEPENDENCE.—State health security programs shall establish safeguards to assure that case coordinators have no financial interest in treatment decisions or placements. Care coordination may not be provided through arrangements which would otherwise prevent the provision of dental care without such a space maintainer that would otherwise be prevented from normal eruption if the space were not maintained; and

(i) is limited to posterior teeth;

(ii) are for spaces for post permanent posterior teeth that would otherwise be prevented from normal eruption if the space were not maintained; and

(iii) do not include a space maintainer that is placed within 6 months of the expected eruption of the permanent posterior tooth concerned.

(C) MEDICAL NEEDED ORAL HEALTH CARE.—The term ‘medically necessary oral health care’ means oral health care that is required as a direct result of, or would have a direct impact on, an underlying medical condition. Such term includes oral health care directed toward control or elimination of pain, infection, or reestablishment of oral function.

(2) SPECIAL NEEDS PATIENT.—The term ‘special needs patient’ includes an individual with a genetic or birth defect, a developmental disability, or an acquired medical disability.

(i) NURSING FACILITY; NURSING FACILITY CARE.—As except as may be provided by the Board, the term ‘nursing facility’ and ‘nursing facility care’ have the meanings given in such terms in sections 1903(a) and 1905(f), respectively, of the Social Security Act.

(j) SERVICES IN INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH MENTAL RETAR—

As except as may be provided by the Board—

(k) OTHER TERMS. As except as may be provided by the Board, the term ‘medically necessary oral health care’ has the meaning specified in section 1903(d) of the Social Security Act (as in effect before the enactment of this title); and

(l) the term ‘services in intermediate care facilities for individuals with mental retardation’ means services described in section 1905(a)(15) of such Act (as so in effect in an intermediate care facility for individuals with mental retardation to an individual determined to require such services in accordance with standards specified by the Board and comparable to those standards described in section 1902(a)(31)(A) of such Act (as so in effect).
SEC. 1103. SPECIAL RULES FOR HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES.

(a) QUALIFYING INDIVIDUALS.—For purposes of section 1101(a)(5)(C), individuals described in this subsection are the following individuals:

(1) ADULTS.—Individuals 18 years of age or older determined (in a manner specified by the Board) to:

(A) be unable to perform, without the assistance of another, at least 2 of the following 5 activities of daily living (or who has a similar level of disability due to cognitive impairment)—

(i) bathing;
(ii) eating;
(iii) dressing;
(iv) toileting; and
(v) transferring in and out of a bed or in and out of a chair;

(B) due to cognitive or mental impairments, require supervision because the individual behaves in a manner that poses health or safety hazards to himself or herself or others; or

(C) due to cognitive or mental impairments, require supervision during activities of daily living.

(2) CHILDREN.—Individuals under 18 years of age determined (in a manner specified by the Board) to meet such alternative ratio as the Board establishes. Such alternative standard shall be comparable to the standard for adults and appropriate for children.

(b) LIMIT ON SERVICES.—

(1) IN GENERAL.—The aggregate expenditures by a State health security program with respect to home and community-based long-term care services in a period (specified by the Board) may not exceed 65 percent (or such alternative ratio as the Board establishes) of the aggregate amount of payment that would have been made under the program during the period if all the home-based long-term care beneficiaries had been residents of nursing facilities in the same area in which the services were provided.

(2) ALTERNATIVE RATIO.—The Board may establish for purposes of paragraph (1) an alternative ratio (of payments for home and community-based long-term care services in a period (specified by the Board)) that is not less than 65 percent (or such alternative ratio as the Board establishes) of the aggregate amount of payment that would have been made under the program during the period if all the home-based long-term care beneficiaries had been residents of nursing facilities in the same area in which the services were provided.

(c) SPECIFIC LIMITATIONS.—

(1) OVERLAP WITH PREVENTIVE SERVICES.—

The aggregate expenditures by a State health security program with respect to home and community-based long-term care services for the period under paragraph (2) of the subsection shall not be considered to be covered under section 1101(a) if they are furnished in a hospital or other services incident thereto, unless—

(i) required to correct a congenital anomaly;

(ii) required to restore or correct a part of the body which has been altered as a result of accidental injury, disease, or surgery; or

(iii) otherwise determined to be medically necessary and appropriate under section 1101(a).

(2) PERSONAL COMFORT ITEMS OR PRIVATE ROOMS IN INPATIENT FACILITIES.—

Any personal comfort items or private rooms in inpatient facilities shall be provided to individuals who are determined to be medically necessary and appropriate under section 1101(a).

(3) MISCELLANEOUS EXCLUSIONS FROM COVERAGE.—

Covered services under this title do not include the following:

(A) Surgery and other procedures (such as orthodontia) performed solely for cosmetic purposes (as defined in regulations) and hospital services, unless otherwise determined to be medically necessary and appropriate under section 1101(a).

(B) Personal comfort items or private rooms in inpatient facilities, unless determined to be medically necessary and appropriate under section 1101(a).

(C) The services of a professional practitioner if they are furnished in a hospital or other facility which is not a participating provider.

(d) NURSING FACILITY SERVICES AND HOME HEALTH SERVICES.—

Nursing facility services and home health services (referred to as post-hospital services, as defined by the Board) furnished to an individual who is not described in section 1163(a) are not covered services unless those services are determined to meet the standards specified in section 1101(a) and, with respect to nursing facility services, to be provided in the least restrictive and most appropriate setting.

SEC. 1105. CERTIFICATION; QUALITY REVIEW; PLANS OF CARE.

(a) CERTIFICATIONS.—State health security programs may require, as a condition of payment for institutional health care services and other services of the type described in subsections 1101(a) and 1855(a) of the Social Security Act, periodic professional certifications of the kind described in such sections.

(b) QUALITY REVIEW.—For requirement that each State health security program establish a quality review program that meets the requirements for such a program under title E, see section 1306(b)(1)(D).

(c) PLAN OF CARE REQUIREMENTS.—A State health security program may require, consistent with standards established by the Board, that payment be provided only as consistent with a plan of care or treatment formulated by one or more providers of the services or other professionals. Such a plan may include, consistent with subsection (b), case management at specified intervals as a further condition of payment for services.

Subtitle C—Provider Participation

SEC. 1201. PROVIDER PARTICIPATION AND STANDARDS.

(a) IN GENERAL.—An individual or other entity furnishing any covered service under a State health security program under this title is not a qualified provider unless the individual or entity—

(1) is a qualified provider of the services under section 1202;

(2) has filed with the State health security program a participation agreement described in subsection (b); and

(3) meets such other qualifications and conditions as are established by the Board or the State health security program under this title.

(b) REQUIREMENTS IN PARTICIPATION AGREEMENT.—

(1) IN GENERAL.—A participation agreement described in this subsection shall be a written contract between a State health security program and a provider that shall provide at least the following:

...
SEC. 1202. QUALIFICATIONS FOR PROVIDERS.

(a) Services to eligible persons will be furnished by the provider without discrimination on the ground of race, national origin, income, religion, age, sex or sexual orientation, or military status (subject to the professional qualifications of the provider) illness. Nothing in this subparagraph shall be construed as requiring the provider or class of services which are outside the scope of the provider’s normal practice.

(b) No charge will be made for any covered services other than for payment authorized by this title.

(c) The provider agrees to furnish such information as may be reasonably required by the Board or the health security program in accordance with uniform reporting standards established under section 1301(f)(1), for—

(i) the making of payments under this title (including the examination of records as may be necessary for the verification of information on which payments are based);

(ii) statistical or other studies required for the implementation of this title; and

(iv) such other purposes as the Board or State may provide.

(D) The provider agrees not to bill the program for any services for which benefits are not available because of section 1104(d).

(E) In the case of a provider that is not an individual, the provider agrees not to employ or use for the provision of health services any individual or other provider who or which has had a participation agreement under this subsection terminated for cause.

(F) In the case of a provider paid under a fee-for-service basis under section 1111, the provider must submit bills and any required supporting documentation relating to the provision of covered services within 30 days (or such shorter period as a State health security program may require) after the date of providing such services.

(2) TERMINATION OF PARTICIPATION AGREEMENTS.

(A) IN GENERAL.—Participation agreements may be terminated, with appropriate notice—

(i) by the Board or a State health security program for failure to meet the requirements of this title; or

(ii) by a provider.

(B) TERMINATION PROCESSES.—Providers shall be provided notice and a reasonable opportunity to correct deficiencies before the Board or a State health security program terminates an agreement unless a more immediate termination is required for public safety or similar reasons.

SEC. 1203. QUALIFICATIONS FOR COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS.

(a) IN GENERAL.—For purposes of this title, a comprehensive health service organization (in this subsection referred to as a "CHSO") is a public or private organization which, in return for a capitated payment amount, undertakes to furnish, arrange for the provision of, or pay providers to provide—

(A) Services to eligible persons will be furnished in such manner as to provide comprehensive health service organizations. Except as the Board may specify in order to carry out this title, a hospital, nursing facility, or other institutional provider (as defined in section 1312) shall not establish standards for such a facility under the medicare program under title XVIII of the Social Security Act. Such standards also may include, where appropriate relating to—

(i) adequacy and quality of facilities;

(ii) training and competency of personnel (including continuing education requirements);

(iii) comprehensiveness of service;

(iv) continuity of service;

(v) patient satisfaction (including waiting time and access to services);

(vi) performance standards (including organization, facilities, structure of services, efficiency of operation, and outcome in palliation, improvement of health, stabilization, care, or rehabilitation).

(b) TRANSITION IN APPLICATION.—If the Board provides for additional requirements for providers under this subsection, any such additional requirement shall be implemented in a manner that provides for a reasonable period during which a previously qualified provider is required to meet such an additional requirement.

(c) EXCHANGE OF INFORMATION.—The Board shall provide for an exchange, at least annually, of quality and utilization programs of information with respect to quality assurance and cost containment.

SEC. 1204. LIMITATION ON CERTAIN PHYSICIAN SERVICES.

(a) APPLICABILITY.—The CHSO’s board of directors must be consumer members with no direct or indirect, personal or family financial relationship to the organization.

(b) REPRESENTATION.—The CHSO’s board of directors must include at least one member who represents health care providers.

(c) PATIENT GRIEVANCE PROGRAM.—Each CHSO must have in effect a patient grievance program and must conduct regularly surveys of the satisfaction of members with services provided by or through the organization.

(d) MEDICAL STANDARDS.—Each CHSO must provide that a comprehensive health service organization associated with the organization will promulgate medical standards, oversee the professional aspects of the delivery of care, provide a pharmacy and drug therapeutics committee, and monitor and review the quality of all health services (including drugs, education, and preventive services).

(e) PREMIUMS.—Premiums or other charges by a CHSO for any services not paid for under this title must be reasonable.

(f) UTILIZATION AND BONUS INFORMATION.—Each CHSO must—

(A) comply with the requirements of section 1876(b)(6) of the Social Security Act (relating to prohibiting incentive plans that provide specific inducements to reduce or limit medically necessary services); and

(B) make available to its membership utilization information and data regarding financial performance, including bonus or incentive payment arrangements to practitioners.

(g) PROVISION OF SERVICES TO ENROLLEES AT INSTITUTIONS OPERATING UNDER GLOBAL BUDGETS.—The organization shall arrange to reimburse for hospital services and other facility-based services (as identified by the Board) for services provided to members of the organization in accordance with the global operating budget of the hospital or facility approved under section 1512.

(h) BROAD MARKETING.—Each CHSO must provide for the marketing of its services (including dissemination of marketing materials) to potential enrollees in a manner that is designed to enroll individuals representative of the different population groups and geographic areas in which the organization operates.

(i) ADDITIONAL REQUIREMENTS.—Each CHSO must meet—

(A) such requirements relating to minimum enrollment; and

(B) such requirements relating to financial solvency.

SEC. 1205. LIMITATION ON CERTAIN PHYSICIAN REFERRALS.

(a) APPLICABILITY.—Application to American Health Security Program. Section 1877 of the Social Security Act, as amended by subsections (b) and (c), shall apply under this title in the same manner as it applies under title XVIII of such Act.

(b) REQUIREMENTS FOR CHSOs. —in applying such section under this title any reference to the Secretary or
title XVIII of the Social Security Act are deemed references to the Board and the American Health Security Program under this title, respectively.

(b) PROHIBITION OF PAYMENT BY MEDICAID OR MEDICARE TO CERTAIN ADDITIONAL DESIGNATED SERVICES.—Section 1877(h)(6) of the Social Security Act (42 U.S.C. 1395nn(h)(6)) is amended by adding at the end the following:

"(M) Ambulance services.";

"(N) Home infusion therapy services.";

(c) ADDITIONS.—Section 1395bbb-5(h) of the Social Security Act (42 U.S.C. 1395bbb-5(h)) is amended—

(1) in subsection (a)(1)(A), by striking "for which payment otherwise may be made under this title" and inserting "for which a charge is imposed";

(2) in subsection (a)(1)(B), by striking "under this title"; and

(3) by amending paragraph (1) of subsection (g) to read as follows:

"(1) DENIAL OF PAYMENT.—No payment may be made under a State health security program for a designated health service for which a claim is presented in violation of subsection (a)(1)(B). No individual, third party payor, or other entity is liable for payment for such a service for which a claim is presented in violation of such subsection."; and

(4) in subsection (g)(3), by striking "for which payment otherwise may be made under paragraph (1)" and inserting "for which such a claim may not be presented under subsection (a)(1)".

Subtitle D—Administration

PART 1—GENERAL ADMINISTRATIVE PROVISIONS

SEC. 1391. AMERICAN HEALTH SECURITY STANDARDS BOARD.

(a) ESTABLISHMENT.—There is hereby established an American Health Security Standards Board.

(b) APPOINTMENT AND TERMS OF MEMBERS.—

(1) IN GENERAL.—The Board shall be composed of—

(A) the Secretary of Health and Human Services;

(B) 6 other individuals (described in paragraph (2)) appointed by the President with the advice and consent of the Senate.

The President shall first nominate individuals to serve on the Board for a term of 6 years, and shall annually report to Congress on the status of implementation of this title.

(d) CHAIR.—The President shall designate 1 of the members of the Board, other than the Secretary, to serve at the will of the President as Chair of the Board.

(e) COMPENSATION.—Members of the Board (other than the Secretary) shall be entitled to compensation at a level equivalent to level II of the Executive Schedule, in accordance with section 5313 of title 5, United States Code.

(f) GENERAL DUTIES OF THE BOARD.—

(1) IN GENERAL.—The Board shall develop policies, procedures, and requirements for designated health services to ensure an adequate national data base regarding health services practitioners, facilities, and the costs of facilities and practitioners providing services. Such standards shall in- clude uniform reporting requirements and standards to ensure an adequate national data base regarding health services practitioners, facilities, and the costs of facilities and practitioners providing services. Such standards shall include uniform reporting standards and requirements to carry out this title, including those related to—

(A) eligibility;

(B) enrollment;

(C) benefits;

(D) provider participation standards and qualifications, as defined in subtitle C;

(E) national and State fund level;

(F) methods for determining amounts of payments to providers of covered services, consistent with part II of subtitle D;

(G) the determination of medical necessity and appropriateness with respect to coverage of certain services;

(H) assisting State health security programs with planning for capital expenditures and service delivery;

(I) planning for health professional education funding (as specified in subtitlE B); and

(J) encouraging States to develop regional planning mechanisms (as described in section 1394(a)(3)).

(2) REGULATIONS.—Regulations authorized by this title shall be issued by the Board in accordance with the provisions of section 553 of title 5, United States Code.

(g) UNIFORM REPORTING STANDARDS; ANNUAL REPORT; STUDIES.—

(1) UNIFORM REPORTING STANDARDS.—

(A) IN GENERAL.—The Board shall establish uniform reporting requirements and standards to ensure an adequate national data base regarding health services practitioners, facilities, and the costs of facilities and practitioners providing services. Such standards shall include uniform reporting standards and requirements that are consistent with part II of subtitle D, to the extent feasible, health outcome measures.

(B) REPORTS.—The Board shall analyze regularly information reported to it, and to State health security programs pursuant to such requirements and standards.

(2) ANNUAL REPORT.—Beginning January 1, of the second year beginning after the date of enactment of this title, the Board shall annually report to Congress on the following:

(A) The status of implementation of the Act;

(B) Enrollment under this title;

(C) Benefits under this title;

(D) Expenditures and financing under this title;

(E) Cost-containment measures and achievements under this title.

(f) Quality assurance.

(g) Health care utilization patterns, including any changes attributable to the program.

(h) Long-range plans and goals for the delivery of health services.

(i) Differences in the health status of the populations of the different States, including income and racial characteristics.

(j) Necessary changes in the education of health personnel.

(K) Plans for improving service to medically underserved populations.

(L) Transition problems as a result of implementation of this title.

(M) Opportunities for improvements under this title.

(3) STATISTICAL ANALYSES AND OTHER STUDIES.—The Board may, either directly or by contract—

(A) make statistical and other studies, on a nationwide, regional, state, or local basis, of any aspect of the operation of this title, including studies of the effect of the Act upon the health of the people of the United States and the effect of comprehensive health services upon the health of persons receiving such services;

(B) develop and test methods of providing through payment for services or otherwise, additional incentives for adherence by providers to standards of adequacy, access, and quality of methods of consumer and peer review and peer control of the utilization of drugs, of laboratory services, and of other services; and methods of consumer and peer review of the quality of services;

(C) develop and test, for use by the Board, records and information retrieval systems and budget systems for health services administration, and develop and test model systems for use by providers of services;

(D) develop and test, for use by providers of services, records and information retrieval systems useful in the furnishing of preventive or diagnostic services;

(E) develop, in collaboration with the pharmaceutical profession, and test, improved administrative practices or improved methods for the reimbursement of independent pharmacies for the cost of furnishing drugs as a covered service; and

(F) make such other studies as it may consider necessary or promising for the evaluation, or for the improvement, of the operation of this title.

(4) REPORT ON USE OF EXISTING FEDERAL HEALTH CARE FACILITIES.—Not later than 1 year after the date of the enactment of this title, the Board shall recommend to the Congress—

(A) the issuance of regulations; or

(B) the determination of the availability of funds and their allocation to implement this title.

(f) COMPENSATION.—The Executive Director of the Board shall be entitled to compensation at a level equivalent to level III of the
Executive Schedule, in accordance with section 5314 of title 5, United States Code.

(i) INSPECTOR GENERAL.—The Inspector General of Act of 1978 (5 U.S.C. App.) is amended—

(1) in section 12(1), by inserting after “Corporation;” the first place it appears the follow- ing: “the Chair of the American Health Security Standards Board;”;

(2) in section 12(2), by inserting after “Res- olution Trust Corporation;” the following: “the American Health Security Standards Board;”;

(3) by inserting before section 9 the fol- lowing:

“Special Provisions Concerning American Health Security Standards Board—

“Sec. 8M. The Inspector General of the American Health Security Standards Board, in addition to the other authorities vested by this Act, shall have the same authority, with respect to the Board and the American Health Security Program under this Act, as the Inspector General for the Department of Health and Human Services has with respect to the Secretary of Health and Human Services and the Medicare and Medicaid Programs, respectively.”

(j) STAFF.—The Board shall employ such staff as the Board may deem necessary.

(k) Access to Information.—The Secretary of Health and Human Services shall make available to the Board all information from sources within the Department or from other sources, pertaining to the duties of the Board.

SEC. 1302. AMERICAN HEALTH SECURITY ADVISORY COUNCIL.

(a) In General.—The Board shall provide for an American Health Security Advisory Council to assist the Board in the performance of its functions, including any recommendations which may appear desirable.

The appointed members shall include, in accordance with subsection (e), individuals who are representative of State health security programs, public health professionals, providers of health services, and employers of employees (who represent the majority of the Council) who are representative of consumers of such services, including a balanced representation of employers, unions, consumer organizations, and population groups with special health care needs. To the greatest extent feasible, the membership of the Council shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

(b) Nomination and Appointment.—Such individuals shall hold office for a term of 4 years, except that—

(1) any member appointed to fill a vacancy occurring during the term for which the member’s predecessor was appointed shall be appointed for the remainder of that term; and

(2) the terms of the members first taking office shall expire, as designated by the Board at the time of appointment, 5 at the end of the first year, 5 at the end of the second year, and 5 at the end of the fourth year after the date of enactment of this Act.

(d) Vacancies.—The Board shall fill any vacancy in the membership of the Council in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Council.

(2) VACANCIES.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the prede- cessor of the member was appointed.

(3) REAPPOINTMENT.—The Board may re- appoint the successor of a member of the Council for a second term in the same manner as the original appointment.

(e) QUALIFICATIONS.—

(1) PUBLIC HEALTH REPRESENTATIVES.—Members of the Council who are representa- tive of State health security programs and public health professionals shall be individ- uals who are familiar with the fi- nancing and delivery of care under public health programs.

(2) PROVIDERS.—Members of the Council who are representative of providers of health care shall be individuals who are outstanding in fields related to medical, hospital, or other health services, or who are representative of organizations or associations of professional health practitioners.

(3) CONSUMERS.—Members who are rep- resentative of consumers of such care shall be individuals who have had to rely on financial interest in the furnishing of health services, who are familiar with the needs of various segments for per- sonal health services and are experienced in dealing with problems associated with the consumption of such services.

(f) DUTIES.—

(1) In General.—It shall be the duty of the Council—

(A) to advise the Board on matters of gen- eral policy, in the formulation of this title, in the formulation of regulations, and in the performance of the Board’s duties under section 1301; and

(B) to study the operation of this title and the utilization of health services under it, with a view to recommending any changes in the administration of the Act or in its provi- sions which may appear desirable.

(2) REPORT.—The Council shall make an annual report to the Board on the perform- ance of its functions, including any rec- ommendations it may have with respect thereto, and the Board shall promptly trans- mit the report to the Congress, together with a report by the Board on any rec- ommendations of the Council that have not been followed.

(g) STAFF.—The Council, its members, and any subcommittee of the Council shall be pro- vided with such such administrative, technical, or other assistance as may be authorized by the Board for carrying out their respective func- tions.

(h) MEETINGS.—The Council shall meet as frequently as the Board deems necessary, but not less than 4 times each year. Upon request by 7 or more members of the 7 or more members it shall be the duty of the Chair to call a meeting of the Council.

(i) COMPENSATION.—Members of the Council shall be reimbursed by the Board for travel and per diem expenses during the performance of duties of the Board in accordance with subchapter I of chapter 5 of title 5, United States Code.

(j) FACIA NOT APPLICABLE.—The provisions of the Federal Advisory Committee Act shall not apply to the Council.

SEC. 1303. COOPERATION WITH PRIVATE ENTITIES.

The Secretary and the Board shall consult with private entities, such as professional so- cieties, organizations of recognized associations of experts, medical schools and academic health centers, con- sumer groups, and labor and business organi- zations, as well as health care organizations, reg- ulations, policy initiatives, and information gathering to assure the broadest and most informed input in the administration of this title. Nothing in this title shall prevent the Secretary from adopting guidelines developed by such a private entity if, in the Secretary’s and Board’s judgment, such guide- lines are generally accepted as reasonable and prudent and consistent with this title.

SEC. 1304. STATE HEALTH SECURITY PROGRAMS.

(a) Submission of Plans.—

(1) IN GENERAL.—Each State shall submit to the Board a plan for a State health security program for providing for health care services to the residents of the State in ac- cordance with this title.

(2) REGIONAL PROGRAMS.—A State may join with 1 or more neighbors to submit to the Board a plan for a regional health security program instead of separate State health security programs.

(b) Regional Planning Mechanisms.—The Board shall provide incentives for States to develop regional planning mechanisms to promote the rational distribution of, ade- quate services to, and the efficient use of, tertiary care facilities, education, and services.

(c) Review and Approval of Plans.—

(1) In General.—The Board shall review plans submitted under subsection (a) and de- termine whether such plans meet the re- quirements for approval. The Board shall not approve a plan unless the Board determines that the plan (or State law) provides, consistent with the provisions of this title, for the following: (A) Payment for required health services for eligible individuals in the State in ac- cordance with this title.

(B) Adequate administration, including the designation of a single State agency respon- sible for the administration (or supervision of the administration) of the program.

(C) The establishment of a State health se- curity budget.

(D) Establishment of payment methodolo- gies (consistent with part II of subtitle E).

(E) Assurances that individuals have the freedom to choose practitioners and other health care providers for services covered under this title.

(F) A procedure for carrying out long-term regional management and planning for the functions with respect to the delivery and distri- bution of health care services that—

(i) ensures participation of consumers of health services and providers of health serv- ices; and

(ii) gives priority to the most acute short- ages and maladies of health per- sons, facilities and regions; and deficien- cies in the delivery of covered services and to the means for the speedy alleviation of these shortcomings.

(G) The licensure and regulation of all health providers and facilities to ensure compliance with Federal and State laws and to promote quality of care.

(H) Establishment of an independent omb-udsmen for consumers to register com- plaints about the organization and adminis- tration of the State health security program and help resolve consumer complaints and disputes between consumers and providers.

(2) Publication of an annual report on the operation of the State health security pro- gram and report to the Board an analysis on cost, progress towards achieving full en- rollement, public access to health services, quality review, health outcomes, health profes- sional training, and the needs of medi- cally underserved populations.

(j) Prohibition of a fraud and abuse preven- tion and control unit that the Inspector Gen- eral shall meet the requirements of section 1309(a).

(K) Prohibition in cases of prohibited physician referrals under section 1294.

PROVISIONS RELATING TO PAYMENTS TO MEDICAID PROVIDERS.—If the Board finds that a State plan sub- mitted under paragraph (1) does not meet the
requirements for approval under this section or that a State health security program or specific portion of such program, the plan for which was previously approved, no longer meets requirements of the Board. In such a case, the Board shall provide notice to the State of such failure and that unless corrective action is taken within a period specified by the Board, the Board shall terminate the State health security program (or specific portions of such program) in receivership under the jurisdiction of the Board. 

State Health Security Advisory Councils.—

(1) IN GENERAL.—For each State, the Governor shall appoint an advisory council (the 'State Health Security Advisory Council' or the 'Advisory Council') to assist the Governor and with respect to the implementation of the State health security program in the State. 

(2) MEMBERSHIP.—Each State Health Security Advisory Council shall be composed of at least 11 individuals. The appointed members shall include individuals who are representative of the State health security program, public health professionals, providers of health services, beneficiaries of such programs, and individuals who shall constitute a majority who are representative of consumers of such services, including a balanced representation of employees, employees, and employer organizations, to the greatest extent feasible, the membership of each State Health Security Advisory Council shall represent the various geographic regions of the State and shall reflect the racial, ethnic, and gender composition of the population of the State. 

(3) DUTIES.—

(A) IN GENERAL.—Each State Health Security Advisory Council shall review and submit comments to the Governor concerning the implementation of the State health security program in the State. 

(B) ASSISTANCE.—Each State Health Security Advisory Council shall provide assistance and technical support to community organizations and public and private non-profit agencies submitting applications for funding under appropriate State and Federal public health programs, with particular emphasis placed on assisting those applicants with broad consumer representation. 

(C) STATE USE OF FISCAL AGENTS.—Each State health security program, using competitive bidding procedures, may enter into such contracts with qualified entities, such as voluntary associations, to assist those applicants with the preparation of applications for funding under appropriate State and Federal programs, with particular emphasis placed on assisting those applicants with broad consumer representation. 

(D) DUTY TO STATE.—Exempt as the Board may provide for good cause shown, in no case may more than 1 contract described in paragraph (1) be entered into under a State health security program. 

SEC. 1305. COMPLEMENTARY CONDUCT OF RELATED HEALTH PROGRAMS.

In performing functions with respect to health care programs, the Board shall fund, develop, evaluate, and train health care programs that will improve the health care delivery system, the regulation of health care services, the regulation of health care professionals, and the regulation of health care facilities. The Board shall commit funds for the purpose of supporting health care delivery system programs, and shall report annually to the Congress on the status of such programs. 

PART II—CONTROL OVER FRAUD AND ABUSE

SEC. 1310. APPLICATION OF FEDERAL SANCTIONS TO ALL FRAUD AND ABUSE UNDER AMERICAN HEALTH SECURITY PROGRAM.

The following sections of the Social Security Act shall apply to State health security programs in the same manner as they apply to State medical assistance plans under title XIX of such Act (except that in applying such provisions any reference to the Secretary of Health and Human Services shall be construed to refer to the Board). 

(1) Section 1128 (relating to exclusion of individuals and entities). 

(2) Section 1128A (civil monetary penalties). 

(3) Section 1128B (criminal penalties). 

(4) Section 1124 (relating to disclosure of ownership and related information). 

(5) Section 1126 (relating to disclosure of certain owners). 

SEC. 1311. REQUIREMENTS FOR OPERATION OF STATE HEALTH CARE FRAUD AND ABUSE CONTROL UNITS.

(a) REQUIREMENT.—In order to meet the requirement of section 1304(b)(1)(i), each State health security program must establish and maintain a health care fraud and abuse control unit (in this section referred to as a "fraud unit") that meets requirements of this section and other requirements of the Board. Such a unit may be a State Medicaid fraud control unit (as described in section 1903(a) of the Social Security Act). 

(b) STRUCTURE OF UNIT.—The fraud unit must—

(1) be a single identifiable entity of the State government; 

(2) be separate and distinct from the State agency with principal responsibility for the administration of the State health security program; and 

(3) meet the following requirements:

(A) It must be a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations. 

(B) If it is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Board, that—

(i) assure its assistance of, and coordination with, the appropriate authority or authorities in the States for prosecution; and 

(ii) assure its assistance of, and coordination with, the appropriate authority or authorities in the States for prosecution; 

(C) It must have a formal working relationship with the Attorney General and have formal procedures (including procedures for its referral of suspected criminal violations to such office) for coordinating the referral of individuals to such office. 

(D) It must have a formal working relationship with the Attorney General and have formal procedures (including procedures for its referral of suspected criminal violations to such office) for coordinating the referral of individuals to such office. 

(2) provide effective coordination of activities between the fraud unit and each office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the State health insurance plan. 

(3) have procedures for reviewing complaints of the abuse and neglect of patients and providers and facilities that receive payments under the State health security program. 

(4) have procedures for reviewing complaints of the abuse and neglect of patients and providers and facilities that receive payments under the State health security program. 

(5) have procedures for reviewing complaints of the abuse and neglect of patients and providers and facilities that receive payments under the State health security program. 

(b) DUTIES OF THE COUNCIL.—The Council shall perform the following duties:

(1) PRACTICE GUIDELINES.—The Council shall evaluate and establish national practice guidelines developed under part B of title IX of the Public Health Service Act. The Council shall provide guidance to determine whether such guidelines should be recognized as a national practice guideline to be used under section 1104(a) for purposes of determining payments under a State health security program. 

(2) STANDARDS OF QUALITY, PERFORMANCE MEASURES, AND MEDICAL REVIEW CRITERIA.—The Council shall review and evaluate each standard of quality, performance measure, and medical review criterion developed under part B of title IX of the Public Health Service Act. The Council shall determine whether the standard, measure, or criterion is appropriate for use in assessing or reviewing the quality of services provided by State health security programs, health care institutions, or health care professionals. 

(3) CRITERIA FOR ENTITIES CONDUCTING QUALITY REVIEWS.—The Council shall develop minimum criteria for entities conducting quality reviews and establish a national program for the coordination and continuous external quality review for State health security programs under section 1403. 

(4) REPORTING.—The Council shall report to the President annually on the conduct of activities under such title and shall report to the Board annually on the conduct of activities under such title and shall report to the Board annually on the conduct of activities under such title and shall report to the Board annually on the conduct of activities under such title and shall report to the Board annually on the conduct of activities under such title and shall report to the Board annually on the conduct of activities under such title and shall report to the Board annually on the conduct of activities under such title and shall report to the Board annually on the conduct of activities under such title and shall report to the Board annually on the conduct of activities under such title.
profession. Five members of the Council shall be physicians. Individuals shall be appointed to the Council on the basis of national reputations for clinical and academic excellence. To the extent feasible, the membership of the Council shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

(3) TERMS OF MEMBERS.—Individuals appointed to the Council shall serve for a term of 5 years, and the terms of 4 of the individuals initially appointed shall be, as designated by the President at the time of their appointment, for 1, 2, 3, and 4 years.

(4) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(5) REAPPOINTMENT.—The President may reappoint any Council member for a second term in the same manner as the original appointment. A member who has served for 2 consecutive 5-year terms shall not be eligible for reappointment until 2 years after the member has ceased to serve.

(e) CHAIR.—The President shall designate 1 of the members of the Council to serve at the will of the President as Chair of the Council.

(f) COMPENSATION.—Members of the Council who are not employees of the Federal Government shall be entitled to compensation at a level equivalent to level II of the Executive Schedule, in accordance with section 5313 of title 5, United States Code.

SEC. 1402. DEVELOPMENT OF CERTAIN METHODOLOGIES, GUIDELINES, AND STANDARDS.

(a) PROFILING OF PATTERNS OF PRACTICE; IDENTIFICATION OF OUTLIERS.—The Council shall adopt methodologies for profiling the patterns of practice of health care professionals and for identifying outliers (as defined in subsection (e)).

(b) CENTERS OF EXCELLENCE.—The Council shall develop guidelines for certain medical procedures designated by the Board to be performed at tertiary care centers which can meet standards for frequency of procedure performance and intensity of support mechanisms that are consistent with the high probability of desired patient outcome. The Board may establish criteria for such a designated procedure may only be provided if the procedure was performed at a center that meets such standards.

(c) REMEDIAL ACTIONS.—The Council shall develop standards for education and sanctions with respect to outliers so as to assure the quality of health care services provided under this Act. The Council shall develop criteria for referral of providers to the State licensing board if education proves ineffective in correcting provider practice patterns.

(d) DISSEMINATION.—The Council shall disseminate to the States—

(1) the methodologies adopted under subsection (a);

(2) the guidelines developed under subsection (b); and

(3) the standards developed under subsection (c), for use by the States under section 1463.

(e) OUTLIER DEFINED.—In this title, the term ‘‘outlier’’ means a health care provider whose pattern of practice, relative to applicable nationwide standards, suggests deficiencies in the quality of health care services being provided.

SEC. 1403. STATE QUALITY REVIEW PROGRAMS.

(a) REQUIREMENT.—In order to meet the requirement of section 401(b)(1)(H), each State health security program shall establish 1 or more qualified entities to conduct quality review and enhancement programs of covered services under the program, in accordance with standards established under subsection (b)(1) (except as provided in subsection (b)(2)) and subsection (c).

(b) FEDERAL STANDARDS.—

(1) IN GENERAL.—The Council shall establish standards with respect to—

(A) the adoption of practice guidelines (whether developed by the Federal Government or other entities);

(B) the identification of outliers (consistent with methodologies adopted under section 1463(a));

(C) the development of remedial programs and monitoring for outliers; and

(D) the application of sanctions consistent with the standards established under section 1402(c).

(2) STATE DISCRETION.—A State may apply under subsection (a) standards other than those established under paragraph (1) so long as the State demonstrates to the satisfaction of the Council on an annual basis that the standards applied have been as efficacious in promoting and improving the quality of care as the application of the standards established under paragraph (1). Positive improvements in quality shall be documented by reductions in rates of clinical care process and improvement in patient outcomes.

(c) QUALIFICATIONS.—An entity is not qualified to conduct quality reviews under subsection (a) unless the entity satisfies the criteria for competence for such entities developed by the Council under subsection 1401(b)(3).

(d) INTERNAL QUALITY REVIEW.—Nothing in this section shall preclude an institutional provider from establishing its own internal quality review and enhancement programs.

SEC. 1404. ELIMINATION OF UTILIZATION REVIEW PROGRAMS; TRANSITION.

(a) INTENT.—It is the intention of this title to replace by January 1, 2013, random utilization controls with a systematic review of patterns of practice that compromise the quality of health care as the application of the standards established under paragraph (1). Positive improvements in quality shall be documented by reductions in rates of clinical care process and improvement in patient outcomes.

(b) SUPERSEDED CASE REVIEWS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the program of quality review provided under the previous sections of this title supersedes all existing Federal requirements for utilization review programs, including requirements for random case-by-case reviews and programs requiring pre-certification of medical procedures on a case-by-case basis.

(2) TRANSITION.—Before January 1, 2013, the Board and the States may continue to establish utilization review standards and mechanisms as may be necessary to effect the transition to pattern of practice-based reviews.

(c) CONSTRUCTION.—Nothing in this subsection shall be construed to—

(A) as precluding the case-by-case review of the provision of care—

(i) in individual incidents where the quality of care lags significantly below the acceptable standards of practice; and

(ii) with respect to a provider who has been determined to be an outlier; or

(B) as precluding the case-by-case management of catastrophic, mental health, or substance abuse cases or long-term care where such management is necessary to achieve appropriate clinical outcomes and comprehensive medical care, as provided for in section 1104.

SEC. 1405. NATIONAL HEALTH SECURITY BUDGET.

(a) NATIONAL HEALTH SECURITY BUDGET.—

(1) IN GENERAL.—By not later than September 1 before the beginning of each year beginning with 2012, the Council shall establish a national health security budget, which—

(A) specifies the total expenditures (including expenditures for administrative costs) to be made by the Federal Government and the States for covered health care services under this title; and

(B) allocates those expenditures among the States consistent with section 1504.

Pursuant to subsection (b), such budget for a year shall not exceed the budget for the preceding year increased by the percentage increase in gross domestic product.

(2) DIVISION OF BUDGET INTO COMPONENTS.—

The national health security budget shall consist of at least 4 components:

(A) A component for quality assessment activities (consistent with the national health security spending growth limit); and

(B) A component for health professional education expenditures.

(C) A component for administrative costs.

(D) A component (in this subtitle referred to as the ‘‘operating component’’) for operating expenditures for other components described in subparagraphs (A) through (C), consisting of amounts not included in the other components. A State may provide for the allocation of this component between capital expenditures and other expenditures.

(3) ALLOCATION AMONG COMPONENTS.—

Taking into account the State health security budget established under this section and the national health security budget allocated among the components in a manner that—

(A) assures a fair allocation for quality assessment activities (consistent with the national health security spending growth limit); and

(B) assures that the health professional education expenditure component is sufficient to provide for the amount of health professional education expenditures sufficient to meet the needs for covered health care services (consistent with the national health security spending growth limit under subsection (b)(2));

(b) BASIS FOR TOTAL EXPENDITURES.—

(1) IN GENERAL.—The total expenditures specified in such budget shall be the sum of the capitation amounts computed under section 1502(a) and the amount of Federal administrative expenditures needed to carry out this title.

(2) NATIONAL HEALTH SECURITY SPENDING GROWTH LIMIT.—For purposes of this part, the national health security spending growth limit described in this paragraph for a year is the percentage increase in the gross domestic product (in current dollars) during the 3-year period beginning with the first quarter of the current year plus the percentage increase in gross domestic product in the second previous year to the first quarter of the previous year minus the percentage increase (if any) in the number of eligible individuals residing in any State the United States established and submitted under section 1503, the Board shall allocate the national health security budget among the components in a manner that—

(A) assures a fair allocation for quality assessment activities (consistent with the national health security spending growth limit); and

(B) assures that the health professional education expenditure component is sufficient to provide for the amount of health professional education expenditures sufficient to meet the needs for covered health care services (consistent with the national health security spending growth limit under subsection (b)(2));

(c) DEFINITIONS.—In this title—

(1) CAPITAL EXPENDITURES.—The term ‘‘capital expenditures’’ means expenses for the purchase, lease, construction, or renovation of capital facilities and for equipment and other expenditures not described as the ‘‘operating component’’ for operating expenditures.

(2) HEALTH PROFESSIONAL EDUCATION EXPENDITURES.—The term ‘‘health professional
education expenditures” means expenditures in hospitals and other health care facilities to cover costs associated with teaching and related research activities.

SEC. 1502. COMPUTATION OF INDIVIDUAL AND STATE CAPITATION AMOUNTS.

(a) CAPITATION AMOUNTS.—

(1) INDIVIDUAL CAPITATION AMOUNTS.—In establishing the national health security budget under section 1501(a) and in computing the national average per capita cost under subsection (b), the Board shall establish a method for computing the capitation amount for each eligible individual residing in each State. The capitation amount for an individual in a State classified within a risk group (established under subsection (d)(2)) is the product of—

(A) a national average per capita cost for all covered health care services (computed under subsection (b));

(B) the State adjustment factor (established under subsection (c)) for the State; and

(C) the risk adjustment factor (established under subsection (d)) for the risk group.

(2) STATE CAPITATION AMOUNT.—

(A) In general.—For purposes of this title, the term “State capitation amount” means, for a State for a year, the sum of the capitation amounts under paragraph (1) for all the residents of the State in the year, as estimated by the Board before the beginning of the year involved.

(B) BY STATE.—National Model.—The Board may provide for the computation of State capitation amounts based on statistical models that fairly reflect the elements that comprise the State capitation amount described in subparagraph (A).

(C) POPULATION INFORMATION.—The Bureau of the Census shall assist the Board in determining the national and per capita health care spending growth limit specified in section 1501(b)(2) for each year.

(b) COMPUTATION OF NATIONAL AVERAGE PER CAPITA COST.

(1) FOR 2010.—For 2010, the national average per capita cost under this paragraph is equal to—

(A) the average per capita health care expenditures in the United States in 2008 (as estimated by the Board);

(B) increased by—

(i) the Board’s estimate of the actual amount of such per capita expenditures during 2009; and

(ii) updated to 2010 by the national health security spending growth limit specified in section 1501(b)(2)

(2) FOR SUCCEEDING YEARS.—For each succeeding year, the national average per capita cost under this subsection is equal to the national average per capita cost computed under this subsection for the previous year increased by the national health security spending growth limit specified in section 1501(b)(2) for the year involved.

(c) STATE ADJUSTMENT FACTORS.—

(1) IN GENERAL.—Subject to the succeeding paragraph, the Board shall provide for a process for the approval of capitation amounts for States’ populations from one-twelfth of the product of—

(A) the national average per capita costs to reflect differences between the State and the United States in—

(i) average labor and nonlabor costs that are necessary to provide covered health services;

(ii) any social, environmental, or geographic condition affecting health status or the need for health care services, to the extent such a condition is not taken into account in the establishment of risk groups under subsection (d); and

(iii) the geographic distribution of the State’s population, particularly the proportion of residents in or residing in sparsely underserved areas, to the extent such a condition is not taken into account in the establishment of risk groups under subsection (d); and

(B) any other factor relating to operating costs required to assure equitable distribution of funds among the States.

(2) MODIFICATION OF HEALTH PROFESSIONAL EDUCATION COMPONENT.—With respect to the portion of the national health security budget allocated for health professional education, the Board shall modify the State adjustment factors so as to take into account—

(A) differences among States in health professional education programs in operation as of the date of the enactment of this title; and

(B) differences among States in their relative need for expenditures for health professional education, taking into account the health professional education expenditures proposed in State health security budgets under section 1503(a).

(3) BUDGET NEUTRALITY.—The State adjustment factors, as modified under paragraph (2), shall be applied under this subsection in a manner that results in neither an increase nor a decrease in the total amount of the Federal contributions to all State health security programs under subsection (b) as a result of the application of such factors.

(4) PHASE-IN.—In applying State adjustment factors under this subsection during the period of 2010 through 2015, the Board shall phase-in, over such period, the use of factors described in paragraph (1) in a manner so that the adjustment factor for a State is based on a blend of such factors and a factor that reflects the relative actual average per capita costs of health services of the different States as of the time of enactment of this title.

(5) PERIODIC ADJUSTMENT.—In establishing the national health security budget before the beginning of each year, the Board shall provide for adjustments in the State adjustment factors under this subsection.

(d) ADJUSTMENTS FOR RISK GROUP CLASSIFICATION.—

(1) IN GENERAL.—The Board shall develop an adjustment factor to the national average per capita costs computed under subsection (b) for each individual classified in each risk group (as designated under paragraph (2)) to reflect the difference between the average national average per capita costs and the national average per capita cost for individuals classified in the risk group.

(2) RISK GROUPS.—The Board shall designate a series of risk groups, determined by the Board, that are necessary to provide for a process for the approval of capitation amounts for States’ populations from one-twelfth of the product of—

(A) the national average per capita costs to reflect differences between the State and the United States in—

(i) average labor and nonlabor costs that are necessary to provide covered health services;

(ii) any social, environmental, or geographic condition affecting health status or the need for health care services, to the extent such a condition is not taken into account in the establishment of risk groups under subsection (d); and

(iii) the geographic distribution of the State’s population, particularly the proportion of residents in or residing in sparsely underserved areas, to the extent such a condition is not taken into account in the establishment of risk groups under subsection (d); and

(B) any other factor relating to operating costs required to assure equitable distribution of funds among the States.

(3) EXPENDITURE BASE.—The Board shall establish a formula for the periodic adjustment of the national health security budget under subsection (a) to reflect changes in the national average per capita costs based on information determined by the Board.

(4) PERIODIC ADJUSTMENT.—In computing the national health security budget before the beginning of each year, the Board shall provide for appropriate adjustments in the risk adjustment factors under this subsection.

SEC. 1503. STATE HEALTH SECURITY BUDGETS.

(a) ESTABLISHMENT AND SUBMISSION OF BUDGETS.—

(1) IN GENERAL.—Each State health security program shall establish and submit to the Board for each year a proposed and a final State health security budget, which specifies the following:

(A) The total expenditures (including expenditures for payments of services provided by health care practitioners; and (IV) expenditures for other covered items and services.

Amounts included in the operating component include amounts that may be used by providers for capital expenditures.

(2) THE TOTAL REVENUES REQUIRED TO MEET THE STATE HEALTH SECURITY BUDGETS.—

The total revenues required to meet the State health security budgets under section 1501 for the year shall include—

(A) the proposed budget deadline;—The proposed budget for a year shall be submitted under paragraphs (1) not later than June 1 for the year.

(3) THE FINAL BUDGET.—The final budget for a year shall include—

(A) be established and submitted under paragraph (1) not later than October 1 for the year, and

(B) take into account the amounts established under the national health security budget under section 1501(a) for the year.

(4) ADJUSTMENT IN ALLOCATIONS PERMITTED.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), in the case of a final budget, a State may change the allocation of amounts among components.

(B) NO SUCH CHANGE MAY BE MADE UNLESS THE STATE HAS PROVIDED PRIOR NOTICE OF THE CHANGE TO THE BOARD.—Such a change may not be made unless the State has provided prior notice of the change to the Board.

(C) DENIAL.—Such a change may not be made if the Board, within such time period as the Board specifies, disapproves such change.

(b) EXPENDITURE LIMITS.—

(1) IN GENERAL.—The total expenditures specified in each State health security budget under subsection (a)(1) shall take into account Federal contributions made under section 1501(a).

(2) LIMIT ON CLAIMS PROCESSING AND BILLING EXPENDITURES.—Each State health security program shall provide that State administrative expenditures, including expenditures for claims processing and billing, shall not exceed 3 percent of the total expenditures under the State health security program, unless the Board determines, on a case-by-case basis, that additional administrative expenditures would improve health care quality and cost effectiveness.

(c) WORKER SUBSIDY.—A State health security program may provide that, for budgets for years before 2013, up to 1 percent of the budget may be used for purposes of providing assistance to workers who are currently performing functions in the administration of the health insurance system and who may experience economic dislocation as a result of the implementation of the program.

(d) APPROVAL PROCESS FOR CAPITAL EXPENDITURES PERMITTED.—Nothing in this subsection shall be construed as preventing a State health security program from providing for a process for the approval of capital expenditures based on information derived from regional planning agencies.

SEC. 1504. FEDERAL PAYMENTS TO STATES.

(a) IN GENERAL.—Each State with an approved State health security program is entitled to an annual payment from the American Health Security Trust Fund, on a monthly basis each year, of an amount equal to one-twelfth of the product of—

(1) the State capitation amount (computed under section 1502(a)(2)) for the State for the year; and

(2) the Federal contribution percentage (established under subsection (b)).

(b) FEDERAL CONTRIBUTION PERCENTAGE.—The Board shall establish a formula for the
establishment of a Federal contribution percentage for each State. Such formula shall take into consideration a State's per capita income and revenue capacity and such other relevant non-facility-based, including the Board determines to be appropriate. In addition, during the 5-year period beginning with 2010, the Board shall provide for a transition adjustment to the formula in order to take into account current expenditures by the State (and local governments thereof) for health services under the State health security program. The weighted-average Federal contribution percentage for all States shall equal 86 percent and in no event shall any State's Federal contribution be less than 81 percent nor more than 91 percent.

(c) Use of Payments.—All payments made under the program or the Board shall specify, in-  
cluding whether the institution or facility is invol-  
ed in the treatment of dually diagnosed  
individuals shall be consistent with the State  
health security budget for such expenditures.  

(2) CONSIDERATIONS.—In developing a budget  
approved under this program, the Board shall  
specify the general manner, consistent with  
section shall be construed as preventing a  
health security program on the basis of the  
health care practitioners.

(2) PROCEDURE.—A State health security program may require that bills for services for  
class of services, be submitted electronically.

(b) PAYMENT BASED ON NEGOTIATED  

(1) IN GENERAL.—Every independent health care practitioner is entitled to be paid, for  
the payment rates included in a proposed oper-  
ating budget.

SEC. 1511. PAYMENTS TO HOSPITALS AND OTHER  
FACILITY-BASED SERVICES FOR OP-  
ERATING EXPENSES ON THE BASIS  
of APPROVED GLOBAL BUDGETS.  

(a) DIRECT PAYMENT UNDER GLOBAL  
BUDGET.—Payment for operating expenses for in-  
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(b) PAYMENT BASED ON NEGOTIATED  

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ating budget.
characteristics (as defined by the State health security program).

(2) ADJUSTMENT FOR SPECIAL HEALTH NEEDS.—The State health security program shall adjust such average amounts to take into account the special health needs, including a disproportionate number of medically underserved individuals, of populations served by the program.

(3) ADJUSTMENT FOR SERVICES NOT PROVIDED.—The State health security program shall adjust such average amounts to take into account the cost of covered health care services that are not provided by the comprehensive health service organization under section 1203(a).

SEC. 1513. PAYMENTS FOR COMMUNITY-BASED PRIMARY HEALTH SERVICES.

(a) IN GENERAL.—In the case of community-based primary health services, subject to subsection (b), payments under a State health security program shall—

(1) be based on a global budget described in section 1510;

(2) be based on the basic primary care capitulation as described in subsection (c) for each individual enrolled with the provider of such services; or

(3) be made on a fee-for-service basis under section 1511.

(b) PAYMENT ADJUSTMENT.—Payments under section 1513(a) may include, in addition, an amount adjusted by the State health security program, to cover the costs of services provided which are not covered by such program, for persons not covered by this title whose health care is essential to overall community health and the control of communicable disease and for whom the cost of such care is otherwise uncompensated;

(2) and an additional amount, as set by the State health security program, to cover the reasonable costs of services provided which are not covered by such program, for persons not covered by this title whose health care is essential to overall community health and the control of communicable disease and for whom the cost of such care is otherwise uncompensated;

(c) Basic Primary Care Capitation Amount.—

(1) IN GENERAL.—The basic primary care capitation amount described in this subsection may be used by a provider that furnishes case management services (as defined in section 1915(s)(2) of the Social Security Act), transportation services, and translation services; and

(3) an additional amount, as set by the State health security program, to cover the costs incurred by a provider in conducting health professional education programs in connection with the provision of such services.

SEC. 1514. PAYMENTS FOR PRESCRIPTION DRUGS.

(a) Establishment of List.—The Board shall establish a list of approved prescription drugs and biologicals that the Board determines are necessary for the maintenance or restoration of health or for the treatment of diseases, and for whom the cost of such care is otherwise uncompensated;

(b) Adjustment for Special Health Needs.—The State health security program shall adjust such average amounts to take into account the special health needs, including a disproportionate number of medically underserved individuals, of populations served by the provider.

(3) Adjustment for Services Not Provided.—The State health security program shall adjust such average amounts to take into account the cost of community-based primary health services that are not provided by the provider.

(c) Community-Based Primary Health Services.—In this section, the term "community-based primary health services" has the meaning given such term in section 1102(a).

SEC. 1515. PAYMENTS FOR APPROVED DEVICES AND EQUIPMENT.

(a) Establishment of List.—The Board shall establish a list of approved durable medical equipment and therapeutic devices and equipment (including eyeglasses, hearing aids, and prosthetic appliances), that the Board determines are necessary for the maintenance or restoration of health or of employability or self-management and eligible for coverage under this title.

(b) Considerations and Conditions.—In establishing the list under subsection (a), the Board shall take into consideration the efficiency, safety, and appropriateness of any device or item contained on such list, and shall attach to any item such conditions as the Board determines appropriate with respect to the circumstances under which, or the frequency with which, the item may be prescribed.

(c) Prices.—For each such listed item covered under this title, the Board shall from time to time determine a price or prices which shall constitute the maximum to be recognized under this title as the cost of such item to a provider thereof. The Board may conduct negotiations, on behalf of State health security programs, with product manufacturers and distributors in determining the applicable product price or prices.

(d) Exclusions.—The Board may exclude from coverage under this title ineffective, unsafe, or overpriced products or services.

SEC. 1516. PAYMENTS FOR OTHER ITEMS AND SERVICES.

In the case of payment for other covered health services, the amount of payment under a State health security program shall be established by the program—

(1) in accordance with payment methodologies which are specified by the Board, after consultation with the American Health Security Advisory Council, or methodologies established by the State under section 1519; and

(2) consistent with the State health security budget.

SEC. 1517. PAYMENT INCENTIVES FOR MENTALLY UNDERSERVED AREAS.

(a) Model Payment Methodologies.—In addition to the payment amounts otherwise provided in this title, the Board shall establish payment methodologies that promote the provision of covered health care services in medically underserved areas, particularly in rural and inner-city underserved areas.

(b) Construction.—Nothing in this subtitle shall be construed as limiting the authority of State health security programs to provide additional incentives, consistent with the State health security budget, to encourage the provision of medically necessary and appropriate services in underserved areas.

SEC. 1518. AUTHORITY FOR ALTERNATIVE PAYMENT METHODOLOGIES.

A State health security program, as part of its plan under section 1304(a), may use a payment methodology other than the methodology required under this part so long as—

(1) such payment methodology does not affect the entitlement of individuals to coverage; or

(2) such payment methodology includes a payment methodology required under this part so long as—

(a) such payment methodology does not affect the entitlement of individuals to coverage; or

SEC. 1520. MANDATORY ASSIGNMENT.

A State health security program, as part of its plan under section 1304(a), may use a payment methodology other than the methodology required under this part so long as—

(a) such payment methodology does not affect the entitlement of individuals to coverage; or

PART III—MANDATORY ASSIGNMENT AND ADMINISTRATIVE PROVISIONS

SEC. 1520. MANDATORY ASSIGNMENT.

(a) No Balance Billing.—Payments for benefits under this title shall constitute payment in full for such benefits and the entity furnishing such benefits shall not bill for any item or service other than payment accepted as payment in full for the item or service.

(b) Enforcement.—If an entity knowingly and willfully bills for an item or service, accepts payment in violation of subsection (a), the Board may impose sanctions against that entity in the same manner in which the Board could impose sanctions against such an entity if the Board is the entity to which the claim was submitted.

SEC. 1521. PROCEDURES FOR REIMBURSEMENT; APPEALS.

(a) Procedures for Reimbursement.—In accordance with standards issued by the Board, a State health security program shall establish a timely and administratively simple appeals process to handle grievances pertaining to payment to providers under this title.

(b) Appeals Process.—Each State health security program shall establish a timely and administratively simple appeals process to handle grievances pertaining to payment to providers under this title.

[...]

December 2, 2009 CONGRESSIONAL RECORD — SENATE S12185
Section 1530. Amendment of 1986 Code; Section 15 Not to Apply.

(a) Amendment of 1986 Code.—Except as otherwise expressly provided, whenever in this subtitle an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section of this title, such amendment or repeal shall be applied to the Trust Fund under this title in the same manner as they applied to the Federal Hospital Insurance Trust Fund under part A of title XVIII of such Act, except that the American Health Security Standards Board shall constitute the Board of Trustees of the Trust Fund.

(b) Transfer of Funds.—Any amounts remaining to the Trust Fund or the Federal Supplementary Medical Insurance Trust Fund after the settlement of claims for payments under title XVIII have been reimbursed shall be transferred into the American Health Security Trust Fund.

Part II—Taxes Based on Income and Wages

Section 1535. Payroll Tax on Employers.

(a) In General.—Section 3111 (relating to tax on employers) is amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new subsection:

"(c) Health Care.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 8.7 percent of the wages (as defined in section 3121(a)) paid by such employer in employment (as defined in section 3121(b))."

(b) Self-Employment Income.—Section 1401 (relating to rate of tax on self-employment income) is redesignated subsection (c) as subsection (d) and inserting after subsection (b) the following new subsection:

"(c) Health Care.—In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to 8.7 percent of the amount of the self-employment income for such taxable year.".

(c) Comparable Taxes for Railroad Service.

(1) Tax on Employers.—Section 3221 is amended by redesignating subsection (c) as subsections (d) and inserting after subsection (b) the following new subsection:

"(c) Health Care.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 8.7 percent of the compensation paid by such employer for services rendered to such employer by his employees.".

(2) Tax on Employees Representatives.—Section 3221 (relating to tax on employee representatives) is amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new paragraph:

"(c) Health Care.—In addition to other taxes, there is hereby imposed on the income of each employee representative a tax equal to 8.7 percent of the compensation received during the calendar year by such employee representative (rendered by such employee representative)."

(3) No Applicable Base.—Subparagraph (A) of section 3221(e)(2) is amended by adding at the end thereof the following new clause:

"(iv) Health Care Taxes.—Clause (i) shall not apply to the taxes imposed by sections 3221(c) and 3221(c)."

(d) Technical Amendment.—(1) Subsection (d) of section 3211, as redesignated by paragraph (2), is amended by striking "(b)" and inserting "(b), (c), and (d)".

(2) Subsection (d) of section 3221, as redesignated by paragraph (1), is amended by striking "(b)" and inserting "(b), (c), and (d)".

(e) Effective Date.—The amendments made by this section shall be in effect for taxable years beginning after December 31, 2009.

Title H—Conforming Amendments to the Employee Retirement Income Security Act of 1974

Section 1601. ERISA Inapplicable to Health Coverage Arrangements Under State Health Security Programs.

Section 4 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003) is amended—

(1) in subsection (a), by striking "(b) or (c)" and inserting "(b), (c), or (d)"; and

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

"(d) The provisions of this title shall not apply to any arrangement forming a part of a State health security program established pursuant to section 1001(b) of the American Health Security Act of 2009.".

Section 1603. Exemption of State Health Security Programs from ERISA Pre-emption.

Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) (as amended by sections 174(b)(3)(B) and 182(b) of this title) is amended by adding at the end thereof the following new paragraph:

"(8) Subsection (a) of this section shall not apply to State health security programs established pursuant to section 1001(b) of the American Health Security Act of 2009.".

Section 1603. Prohibition of Employee Benefits Duplicative of Benefits Under State Health Security Programs; Coordination in Case of Workers' Compensation.

(a) In General.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end thereof the following new subsection:

"(c) Prohibition of Employee Benefits Duplicative of Benefits Under State Health Security Programs; Coordination in Case of Workers’ Compensation.—

"(a) General Rule.—Subchapter A of chapter 1 (relating to determination of tax liability) is amended by adding at the end thereof the following new part:

"PART VIII—Health Care Income Tax on Individuals

"(a) Imposition of Tax.—In the case of an individual, there is hereby imposed a tax (in addition to any other tax imposed by this title) equal to 2.85 percent of the taxable income of the taxpayer for the taxable year.

"(b) No Credits Against Tax; No Effect on Minimum Tax.—The tax imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(1) the amount of any credit allowable under this chapter, or

"(2) the amount of the minimum tax imposed by section 55.

"(c) Special Rules.—(1) Tax to be Withheld, etc.—For purposes of this title, the tax imposed by this section shall be treated as imposed by section 1.

"(2) Reimbursement of Tax by Employer Not included in Gross Income.—The gross income of an employee shall not include any amount of the tax paid by the employer for the tax paid by the employee under this section.

"(3) Other Rules.—The rules of section 59A(d) shall apply to the tax imposed by this section.

(b) Clerical Amendment.—The table of parts for subchapter A of chapter 1 is amended by adding at the end the following new item:

"PART VIII—Health Care Income Tax on Individuals"

(c) Effective Date.—The amendments made by this section shall not apply to taxable years beginning after December 31, 2010.

Subtitle H—Conforming Amendments to the Employee Retirement Income Security Act of 1974
which duplicate payment for any items or services for which payment may be made under a State health security program established pursuant to section 106(b) of the Employee Retirement Income Security Act of 1974.

"(b)(1) Each workers compensation carrier that is liable for payment for workers compensation services furnished in a State shall reimburse the State health security plan for the State in which such services are furnished for the cost of such services.

"(2) In this subsection:

"(A) The term ‘workers compensation carrier’ means an insurance company that underwrites workers compensation medical benefits with respect to 1 or more employers and includes an employer or fund that is financially at risk for the provision of workers compensation medical benefits.

"(B) The term ‘workers compensation medical benefits’ means, with respect to an enrollee who is an employee subject to the workers compensation laws of a State, the comprehensive medical benefits for work-related injuries and illnesses provided for under such laws with respect to such an employee.

"(C) The term ‘workers compensation services’ means items and services included in workers compensation medical benefits and includes services (including rehabilitation services and long-term-care services) commonly used for treatment of work-related injuries and illnesses.

(b) CONFORMING AMENDMENT.—Section 4(b) of such Act (29 U.S.C. 1000(b)) is amended by adding at the end the following: "Paragraph 4(b)(1) shall apply subject to section 533(b) (repealing at the end the following: ‘Paragraph (3) shall apply subject to section 533(b) (re- 
ating to reimbursement of State health security plans by workers compensation carriers.’)."

(c) CEREMONIAL AMENDMENT.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 518 the following new items:

"Sec. 519. Prohibition of employee benefits duplicative of state health security program benefits; coordination in case of workers’ compensation.’’

SEC. 1604. REPEAL OF CONTINUATION COVERAGE REQUIREMENTS UNDER ERISA AND CERTAIN OTHER REQUIREMENTS RELATING TO GROUP PLANS

(a) IN GENERAL.—Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(a)) is amended—

(1) by striking paragraph (7); and

(2) by redesignating paragraphs (8), (9), and (10) as paragraphs (7), (8), and (9), respectively.

(b) CONFORMING AMENDMENTS.—

(1) Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(A) by striking paragraph (7); and

(B) by redesignating paragraphs (8), (9), and (10) as paragraphs (7), (8), and (9), respectively.

(2) Section 502(c) of such Act (29 U.S.C. 1132(c)1) is amended by striking ‘paragraph (1) or (4) of section 606.’

(c) SEC. 931. HEALTH CARE DELIVERY SYSTEM RESEARCH, QUALITY IMPROVEMENT PROGRAMS

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) by redesigning paragraph (2) as paragraph (1) of the section;

(2) by redesigning paragraphs 931 through 938 as sections 941 through 948, respectively;

(3) in section 946(1), as so redesignated, by striking ‘931’ and inserting ‘941’; and

(4) by inserting after section 926 the following:

‘PART D—HEALTH CARE QUALITY IMPROVEMENT PROGRAMS’

‘SEC. 931. HEALTH CARE DELIVERY SYSTEM RESEARCH, QUALITY IMPROVEMENT PROGRAMS

(a) PURPOSE.—The purposes of this section are to—

(1) enable the Director to identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices (referred to as ‘best practices’) in health care quality, safety, and value

and

(2) ensure that the Director is accountable for implementing a model to pursue such research in a collaborative manner with other related Federal agencies.

(b) GENERAL FUNCTIONS OF THE CENTER.

The Center for Healthcare Research and Quality (referred to in this section as the ‘Center’), or any other relevant agency or program designated by the Director, shall—

(1) carry out its functions using research from a variety of disciplines, which may include epidemiology, health services research, sociology, psychology, public health sciences, biostatistics, health economics, clinical research, and health informatics;

and

(2) conduct research and activities consistent with the purposes described in subsection (a), and for—

(1) best practices for quality improvement practices in the delivery of health care services;

and

(2) that include changes in processes of care, the redesign of health care delivery systems used by providers that will reliably result in intended health outcomes, improve patient safety, and reduce medical errors (such as skill development for health care providers in team-based health care delivery and rapid cycle process improvement) and facilitate adoption of improved workflow.

(i) identify health care providers, including health care systems, single institutions, and individual providers, that—

(A) deliver consistently high-quality, efficient, and effective health care services (as determined by the Secretary); and

(B) employ best practices that are adaptable and scalable to diverse health care settings or effective in improving care across diverse settings;

(ii) assess research, evidence, and knowledge about what strategies and methodologies are most effective in improving health care delivery;

(iii) find ways to translate such information rapidly and effectively into practice, and document the sustainability of those improvements;

(iv) create strategies for quality improvement through the development of tools, methodologies, and interventions that can successfully reduce variations in the delivery of health care;

(v) identify, measure, and improve organizational, human, or other causative factors, including those related to the culture and systems design of a health care organization, that contribute to the success and sustainability of specific quality improvement and patient safety strategies;

(vi) provide for the development of best practices in the delivery of health care services that—

(A) have a high likelihood of success, based on structured review of empirical evidence;

(B) are specified with sufficient detail of the individual processes, steps, training, skills, and knowledge required for implementation and incorporation into workflow of health care practitioners in a variety of settings;

(C) are designed to be readily adapted by health care providers in a variety of settings; and

(D) where applicable, assist health care providers in working with other health care providers across the continuum of care and their engagement in their roles in improving the care and patient health outcomes;

(vii) provide for the funding of the activities of organizations with recognized expertise and excellence in improving the delivery of health care services, including children’s health care, by involving multiple disciplines, managers of health care entities, broad development and training, patients, caregivers and families, and frontline health care workers, including activities for the examination of strategies to share best quality improvement practices and to promote excellence in the delivery of health care services for heal-

(viii) build capacity at the State and community level to lead quality and safety ef-

(f) RESEARCH FUNCTIONS OF CENTER.—

(1) IN GENERAL.—The Center shall sup-

SEC. 1701. REPEAL OF CERTAIN PROVISIONS IN INTERNAL REVENUE CODE OF 1986.

The provisions of titles III and IV of the Health Insurance Portability and Accountability Act of 1996, other than subtitles D and H of title III and section 342, are repealed and the provisions of law that were amended by such provisions are hereby restored as if such provisions had not been enacted.

SEC. 1702. REPEAL OF CERTAIN PROVISIONS IN THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is repealed and the items relating to such part in section 1 of such Act are repealed.

(b) CONFORMING AMENDMENT.—Section 514(b) of such Act (29 U.S.C. 1144(b)) is amended by striking paragraph (9).

SEC. 1703. REPEAL OF CERTAIN PROVISIONS IN THE PUBLIC HEALTH SERVICE ACT AND RELATED PROVISIONS.

(a) IN GENERAL.—Titles XXII and XXVII of the Public Health Service Act are repealed.

(b) ADDITIONAL AMENDMENTS.—

(1) Section 330(b) of such Act (42 U.S.C. 206(d)(3)(b)(i)) is amended by striking paragraph (9).

(2) Section 502(c)(1) of such Act (29 U.S.C. 1132(c)(1)) is amended by striking ‘paragraph (1) or (4) of section 606.’

(3) Section 514(b) of such Act (29 U.S.C. 1144(b)) is amended—

(A) in paragraph (7), by striking ‘section 206(d)(3)(B)(ii),’ and all that follows and in- 

cluding ‘section 206(d)(3)(B)(iv).’; and

(B) by striking paragraph (8).

(4) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by striking the items relating to part 6 of subtitle B of title I of such Act.

SEC. 1805. EFFECTIVE DATE OF SUBTITLE.

The amendments made by this subtitle shall take effect January 1, 2012.
that improve the quality, safety, and efficiency of health care delivery services. Such support may include establishing a Quality Improvement Network Research Program for the purpose of testing, scaling, and disseminating of interventions to improve quality and efficiency in health care. Recipients of funding under the Program may include national or local, or multi-site quality improvement networks.

"(2) RESEARCH REQUIREMENTS.—The research conducted pursuant to paragraph (1) shall—

(A) address concerns identified by health care institutions and providers and communicate through the Center pursuant to subsection (a)(1); and

(B) reduce preventable morbidity, mortality, and associated costs of morbidity and mortality by building capacity for patient safety research;

(C) support the discovery of processes for the reliable, safe, efficient, and responsive delivery of health care, taking into account discoveries from clinical research and comparative effectiveness research;

(D) allow communication of research findings and translate evidence into practice recommendations and improved quality in a variety of settings and, which, as soon as practicable after the establishment of the Center, shall include—

(i) implementation of a national application of Intensive Care Unit improvement projects relating to the adult (including geriatric), pediatric, and neonatal patient populations;

(ii) practical methods for addressing health care associated infections, including Methicillin-Resistant Staphylococcus Aureus and Vancomycin-Resistant Enterococcus infections and other emerging infections; and

(iii) practical methods for reducing preventable hospital admissions and readmissions;

(E) expand demonstration projects for improving the quality of children’s health care and the use of health information technology, such as through Pediatric Quality Improvement Collaboratives and Learning Networks, consistent with provisions of section 1310 in the Social Security Act for assessing and improving quality, where applicable;

(F) identify and mitigate hazards by—

(i) analyzing events reported to patient safety reporting systems and patient safety organizations; and

(ii) using the results of such analyses to develop specific methods of response to such events;

(G) include the conduct of systematic reviews of existing practices that improve the quality, safety, and efficiency of health care delivery, as well as new research on improving such practices; and

(H) include the examination of how to measure and evaluate the progress of quality and patient safety activities.

"(d) DISSEMINATION OF RESEARCH FINDINGS.—

(1) PUBLIC AVAILABILITY.—The Director shall make the research findings of the Center available to the public through multiple media and appropriate formats to reflect the varying needs of health care providers and consumers and diverse levels of health literacy.

(2) LINKAGE TO HEALTH INFORMATION TECHNOLOGY REGIONAL EXTENSION CENTERS.—The Secretary shall ensure that the research findings and results generated by the Center are shared with the Office of the National Coordinator for Health Information Technology Regional Extension Centers to inform the activities of the health information technology extension program under section 3012, as well as any relevant standards, certification criteria, or implementation specifications.

"(e) PRIORITIZATION.—The Director shall—

(1) the cost of federal health programs;

(2) consumer assessment of health care experience;

(3) provider assessment of such processes or systems as to minimize patient distress and injury to the health care workforce;

(4) the potential impact of such processes or systems on functional outcomes of patients, including vulnerable populations including children;

(5) the areas of insufficient evidence identified under paragraph (1); and

(6) the evolution of meaningful use of health information technology, as defined in section 3009.

"(f) FUNDING.—There is authorized to be appropriated to carry out this section $20,000,000 for fiscal years 2010 through 2014.

"SEC. 932. QUALITY IMPROVEMENT TECHNICAL ASSISTANCE AND IMPLEMENTATION.

"(a) IN GENERAL.—The Director, through the Center for Quality Improvement and Patient Safety, may conduct Quality Improvement Research (referred to in this section as the ‘Center’), shall award—

(1) technical assistance grants or contracts to eligible entities to provide technical support to institutions that deliver health care and health care providers (including rural and urban providers of services and suppliers with limited infrastructure and financial resources to implement and support quality improvement activities, providers of services and suppliers with low performance scores, and providers of services and suppliers for which there are disparities in care among subgroups of patients) so that such institutions and providers understand, adapt, and implement the models and practices identified in the research conducted by the Center, including the Quality Improvement Networks Research Program; and

(2) implementation grants or contracts to eligible entities to implement the models and practices described under paragraph (1).

"(b) ELIGIBLE ENTITY.—

(1) TECHNICAL ASSISTANCE AWARD.—To be eligible to receive a technical assistance grant or contract under subsection (a)(1), an entity—

(A) may be a health care provider, health care provider association, professional society, health care worker organization, Indian health organization, quality improvement organization, patient safety organization, local quality improvement collaborative, the Joint Commission, academic health center, university, academic health center, health care system, professional organization, or any other entity identified by the Secretary at such time, in such manner, and containing—

(1) a plan for a sustainable business model for the management and support of the Center, including the Quality Improvement Networks Research Program; and

(2) an evaluation program established under section 399W; and

(B) may be a health care provider, health care provider association, professional society, health care worker organization, or any other entity identified by the Secretary at such time, in such manner, and containing—

(1) the cost of federal health programs;

(2) consumer assessment of health care experience;

(3) provider assessment of such processes or systems as to minimize patient distress and injury to the health care workforce;

(4) the potential impact of such processes or systems on functional outcomes of patients, including vulnerable populations including children;

(5) the areas of insufficient evidence identified under paragraph (1); and

(6) the evolution of meaningful use of health information technology, as defined in section 3009.

"(c) APPLICATION.—

(1) TECHNICAL ASSISTANCE AWARD.—To receive a technical assistance grant or contract under subsection (a)(1), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

(A) a plan for implementation of a model or practice identified in the research conducted by the Center including—

(i) financial cost, staffing requirements, and timeline for implementation; and

(ii) pre- and projected post-implementation quality measure performance data in tandem with improvement areas identified by the Secretary; and

(B) such other information as the Director may require.

"(2) IMPLEMENTATION AWARD.—To receive a grant or contract under subsection (a)(2), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

(A) a plan for implementation of a model or practice identified in the research conducted by the Center including—

(i) financial cost, staffing requirements, and timeline for implementation; and

(ii) pre- and projected post-implementation quality measure performance data in tandem with improvement areas identified by the Secretary; and

(B) such other information as the Director may require.

"(d) MATCHING FUNDS.—The Director may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to 50 percent of the Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in-kind, fairly evaluated, including plant, equipment, or services.

(2) EFFECT OF EVALUATION.—Based on the outcome of the evaluation of the entity under paragraph (1), the Director shall determine whether to renew the technical assistance contract with such entity under this section.

(3) COORDINATION.—The entities that receive a grant or contract under this section shall coordinate with health information technology regional extension centers under section 3012 and the primary care extension program established under section 399W regarding the dissemination of quality improvement, system delivery reform, and best practices information.

SEC. 2002. ESTABLISHING COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME.

"(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ‘Secretary’), shall—

(1) establish a program to provide grants to or enter into contracts with eligible entities to establish...
community-based interdisciplinary, interprofessional teams (referred to in this section as “health teams”) to support primary care practices, including obstetrics and gynecology providers within the hospital service areas served by the eligible entities.

Grants or contracts shall be used to—

(1) provide primary care providers to provide support services to primary care providers; and

(2) provide capitated payments to primary care providers as determined by the Secretary.

(b) Eligible Entities.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

(1) be a State or State-designated entity; or

(2) be an Indian tribe or tribal organization, as defined in section 4 of the Indian Health Care Improvement Act.

(2) submit a plan for achieving long-term financial sustainability within 3 years;

(3) submit a plan for incorporating prevention initiatives and patient education and care management resources into the delivery of health care that is integrated with community-based prevention and treatment resources, where available; and

(4) ensure that the health team established by the entity includes an interdisciplinary, interprofessional team of health care providers, as determined by the Secretary; such team may include medical specialists, nurses, pharmacists, nutritionists, dieticians, mental health providers, and behavioral health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed clinical social workers, alternative medicine practitioners, and physicians’ assistants;

(5) agree to provide services to eligible individuals with chronic conditions in accordance with the payment methodology established under subsection (c) of this section; and

(6) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) Requirements for Health Teams.—A health team established pursuant to a grant or contract under subsection (a) shall—

(1) establish contractual agreements with primary care providers to provide support services;

(2) support patient-centered medical homes, defined as a mode of care that includes—

(A) personal physicians;

(B) whole person orientation;

(C) coordinated and integrated care;

(D) the ability to include through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements;

(E) transitional care; and

(F) payment that recognizes added value from additional components of patient-centered care;

(c) collaborate with local primary care providers and existing State and community-based resources to coordinate disease prevention, chronic disease management, transition of care between health care providers and settings and case management for patients, including children, with priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(d) in collaboration with local health care providers, develop and implement interdisciplinary, interprofessional care plans that integrate clinical and community preventive and health promotion services for patients, including children, with a priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(e) incorporate health care providers, patients, caregivers, and authorized representatives in program design and oversight;

(f) provide support necessary for local primary care teams to—

(A) coordinate and provide access to high-quality health care services;

(B) coordinate and provide access to preventive and health care services;

(C) provide access to appropriate specialty care and inpatient services;

(D) provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care;

(E) provide access to pharmacist-delivered medication management services, including medication reconciliation;

(F) provide coordination of the appropriate use of complementary and alternative (CAM) services, including such services as acupuncture, chiropractic care, and osteopathic medicine; and

(G) promote effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care to avoid duplication of service and other medical management approaches intended to improve quality and value of health care services;

(g) provide local access to the continuum of health care services in the most appropriate setting, including access to individual care providers that implement the care plans of patients and coordinate care, such as integrative health care practitioners;

(h) submit a report to the Secretary that permits evaluation of the impact of the collaborative effort on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement; and

(i) establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems such as through the use of infolines, health information technology, or other means as determined by the Secretary;

(j) provide 24-hour care management and support during transition in care settings including—

(A) a transitional care program that provides onsite visits from the care coordinator, assists with the development of discharge plans and medication reconciliation upon admission to and discharge from the hospitals, nursing homes, and other institutions under subsection (c) of this section;

(B) discharge planning and counseling support to providers, patients, caregivers, and authorized representatives;

(C) assuring that discharge care plans include medication management, as appropriate;

(D) referrals for mental and behavioral health services, which may include the use of infolines; and

(E) transitional health care needs from adolescence to adulthood;

(k) serve as a community prevention and treatment programs; and

(l) promote a capacity to implement and maintain health information technology that meets the requirements of certified EHR technology (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 300jj)) to facilitate coordination among members of the health team and affiliated primary care practices.

(d) Requirement for Primary Care Providers.—A provider who contracts with a care team shall—

(1) provide a care plan to the care team for each patient participant;

(2) provide access to participant health records; and

(3) meet regularly with the care team to ensure integration of care.

(e) Reporting to Secretary.—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out by the entity under subsection (c).

(f) Definition of Primary Care.—In this section, the term “primary care” means the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

SEC. 953. MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASES.

(a) IN GENERAL.—The Secretary, acting through the Patient Safety Research Center (hereafter in this section referred to as the ’Center’), shall establish a program to provide grants or contracts to eligible entities to implement medication management (referred to in this section as ‘MTM’) services provided by licensed pharmacists, as a collaborative, multidisciplinary team to improve the treatment of chronic diseases for targeted individuals, to improve the quality of care and reduce overall cost in the treatment of such diseases.

(b) Eligible Entities.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

(1) provide a setting appropriate for MTM services as recommended by the experts described in subsection (e);

(2) submit to the Secretary a plan for achieving long-term financial sustainability;

(3) where applicable, submit a plan for coordinating MTM services through local community health teams established in section 3502 of the Patient Protection and Affordable Care Act; and

(4) submit a plan for meeting the requirements of subsection (c); and

(5) submit to the Secretary such other information as the Secretary may require.

(c) MTM Services to Targeted Individuals.—The MTM services provided to an individual with the assistance of a grant or contract awarded under subsection (a) shall, as allowed by State law—

(1) performing or obtaining necessary assessments of the health and functional status of each patient receiving such MTM services;

(2) formulating a medication treatment plan according to therapeutic goals agreed upon by the prescribing health professional or his or her authorized representative and the patient or caregiver or authorized representative of the patient;

(3) selecting, initiating, modifying, recommending changes to, or administering medication therapy;

(4) monitoring, which may include access to, ordering, or performing laboratory assessments, and evaluating the response of the patient to therapy, including safety and effectiveness;

(5) performing an initial comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events, quarterly targeted medication reviews for ongoing monitoring, and additional followup interventions on a schedule developed collaboratively with the prescriber;
"(6) documenting the care delivered and communicating essential information about such care, including a summary of the medication review, and the recommendations of the pharmacist to other appropriate health care providers of the patient in a timely fashion;

"(7) providing education and training designed to enhance patient adherence with therapeutic regimens;

"(8) coordinating and integrating MTM services within the broader health care management services provided to the patient;

"(9) such other patient care services allowed under pharmacist scopes of practice in use in other Federal programs that have implemented MTM services.

"(d) TARGETED INDIVIDUALS.—MTM services provided by licensed pharmacists under a grant or contract awarded under subsection (a) shall be offered to targeted individuals who—

"(1) take 4 or more prescribed medications (including over-the-counter medications and dietary supplements); and

"(2) take any 'high risk' medications;

"(3) have 2 or more chronic diseases, as identified by the Secretary; or

"(4) undergo a transition of care, or other factors, as determined by the Secretary, that are likely to create a high risk of medication-related problems.

"(e) CONFLICTS OF INTEREST.—In designing and implementing MTM services provided under grants or contracts awarded under subsection (a), the Secretary shall consult with Federal, State, private, and academic entities, pharmacy and pharmacist organizations, health care organizations, consumer advocates, chronic disease groups, and other stakeholders involved with the research, dissemination, and implementation of pharmacist-delivered MTM services so that the Secretary determines appropriate. The Secretary, in collaboration with this group, shall determine whether it is possible to incorporate rapid cycle process improvement techniques using only those Federal programs that have implemented MTM services.

"(f) REPORTING TO THE SECRETARY.—The eligible entity that serves a population in a multicounty area, or a similar area within a State, an area that lies within multiple States, or a similar area (such as a Federal or regional area) in a timely fashion;

"(g) EVALUATION AND REPORT.—The Secretary shall submit to the relevant committees of Congress a report which shall include—

"(1) the clinical effectiveness of pharmacist-provided services under the MTM services program, as compared to usual care, including an evaluation of whether enrollees maintain better health with fewer hospitalizations and emergency room visits than similar patients not enrolled in the program;

"(2) assess changes in overall health care resource use by targeted individuals;

"(3) assess patient and prescriber satisfaction with MTM services;

"(4) assess the impact of patient-cost sharing requirements on medication adherence and recommendations for modifications;

"(5) identify and evaluate other factors that may influence patient and health care outcomes, including demographic characteristics, clinical characteristics, and health

services use of the patient, as well as character-

istics of the regimen, pharmacy benefit, and MTM services provided; and

"(6) evaluate the extent to which partici-

pating pharmacist contracts and per-

fusing role have a conflict of interest in the provision of MTM services, and if such con-

flict is found, provide recommendations on how such a conflict might be appropriately addressed.

"(7) GRANTS OR CONTRACTS TO FUND DEVELOP-

MENT OF PERFORMANCE MEASURES.—The Secretary shall award grants or contracts to eligible entities for the purpose of funding the development of performance measures that assess the effectiveness of med-

ication therapy management services.

"SEC. 2004. DESIGN AND IMPLEMENTATION OF RE-

GIONALIZED SYSTEMS FOR EMER-

GENCY CARE.

"(a) IN GENERAL.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended—

"(1) in section 1203—

"(A) in the section heading, by inserting "FOR TRAUMA SYSTEMS" after "GRANTS"; and

"(B) in subsection (a), by striking "Administrator of the Health Resources and Services Administration" and inserting "Assistant Secretary for Preparedness and Response"; and

"(2) by inserting after section 1203 the fol-

lowing:

"SEC. 1204. COMPETITIVE GRANTS FOR REGION-

ALIZED SYSTEMS FOR EMERGENCY CARE RESPONSE.

"(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Pre-

paredness and Response, shall award grants or contracts of not less than $1 for each $3 of Fed-

eral contributions required in paragraph (2) toward such costs in an amount equal to not less than $1 for each $3 of Federal funds provided for such grants. Such con-

tributions may be made directly or through donations from public or private entities.

"(2) NON-FEDERAL CONTRIBUTIONS.—Non-

Federal contributions required in paragraph (1) (may be in cash or in kind, fairly evalu-

ated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the Federal Govern-

ment, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in deter-

mining the amount of such non-Federal contrib-

utions.

"(f) PRIORITY.—The Secretary shall give priority for the award of the contracts or grants to eligible entities that serve a population in a medically underserved area (as defined in section 338(b)(3)).

"Not later than 90 days after the completion of a pilot project under subsection (a), the recipient of such contract or
grant described in this shall submit to the Secretary a report containing the results of an evaluation of the program, including—

(a) a description of—

(1) the impact of the regional, accountable emergency care system on patient health outcomes for various critical care categories, such as trauma, stroke, cardiac emergency care, and pediatric emergencies;

(2) the model of service delivery and the components of such models that contribute to the enhanced patient health outcomes; and

(3) the translation of basic scientific research into improved practice; and

(b) the development of timely and efficient delivery of health services.

(b) PEDIATRIC EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies involved in improving the emergency care system to expand and accelerate research in emergency medical care systems and pediatric emergency medicine, including—

(1) an examination of the gaps and opportunities in pediatric emergency care research and a strategy for the optimal organization and funding of such research;

(2) the development of emergency services as an integrated component of the overall health system;

(3) system-wide pediatric emergency care planning, preparedness, coordination, and funding;

(4) pediatric training in professional education; and

(5) research in pediatric emergency care, specifically on the efficacy, safety, and health outcomes of medications used for infants, children, and adolescents in emergency care settings in order to improve patient safety.

(c) IMPACT RESEARCH.—The Secretary shall support research to determine the estimation of, and savings that result from, the implementation of coordinated emergency care systems.

(d) AUTHORIZATION.—There are authorized to be appropriated—

(1) the basic science of emergency medicine, including—

(A) dissemination of findings to the public and to the appropriate Committees of the Congress, the information contained in a report made under subsection (e); and

(B) dissemination of findings to the public and to the appropriate Committees of the Congress, the information contained in a report made under subsection (e); and

(2) the role of pediatric emergency services and pediatric emergencies,

(3) the translation of basic scientific research into improved practice; and

(4) the development of timely and efficient delivery of health services.

SEC. 498D. SUPPORT FOR EMERGENCY MEDICAL RESEARCH.

(a) EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies involved in improving the emergency care system to expand and accelerate research in emergency medical care systems and pediatric emergency medicine, including—

(1) the basic science of emergency medicine;

(2) the model of service delivery and the components of such models that contribute to the enhanced patient health outcomes;

(3) the translation of basic scientific research into improved practice; and

(4) the development of timely and efficient delivery of health services.

(b) PEDIATRIC EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies to coordinate and expand research in pediatric emergency medical care systems and pediatric emergency medicine, including—

(1) an examination of the gaps and opportunities in pediatric emergency care research and a strategy for the optimal organization and funding of such research;

(2) the development of emergency services as an integrated component of the overall health system;

(3) system-wide pediatric emergency care planning, preparedness, coordination, and funding;

(4) pediatric training in professional education; and

(5) research in pediatric emergency care, specifically on the efficacy, safety, and health outcomes of medications used for infants, children, and adolescents in emergency care settings in order to improve patient safety.

(c) IMPACT RESEARCH.—The Secretary shall support research to determine the estimation of, and savings that result from, the implementation of coordinated emergency care systems.

(d) AUTHORIZATION.—There are authorized to be appropriated—

(1) the basic science of emergency medicine, including—

(A) dissemination of findings to the public and to the appropriate Committees of the Congress, the information contained in a report made under subsection (e); and

(B) dissemination of findings to the public and to the appropriate Committees of the Congress, the information contained in a report made under subsection (e); and

(2) the role of pediatric emergency services and pediatric emergencies,

(3) the translation of basic scientific research into improved practice; and

(4) the development of timely and efficient delivery of health services.

SEC. 2005. PROGRAM TO FACILITATE SHARED DECISION-MAKING.

Part D of title IX of the Public Health Service Act, as amended by section 2003, is further amended by adding at the end the following:

SEC. 834. PROGRAM TO FACILITATE SHARED DECISION-MAKING.

(a) PURPOSE.—The purpose of this section is to facilitate collaborative processes between patients, caregivers or authorized representatives, and clinicians that engages the patient, caregiver or authorized representative in decisionmaking, provides patients, caregivers or authorized representatives with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the decisionmaking process.

(b) DEFINITIONS.—In this section:

(1) PATIENT DECISION AID.—The term "patient decision aid" means an educational tool that helps patients, caregivers or authorized representatives understand and communicate their beliefs and preferences related to their treatment options, and to decide with their healthcare providers which treatments are best for them based on their treatment options, scientific evidence, circumstances, benefits, harms and preferences.

(2) PREFERENCE SENSITIVE CARE.—The term "preference sensitive care" means medical care for which the clinical evidence does not clearly support one treatment option such that the appropriate course of treatment depends on the values of the patient or the preferences of the patient, caregivers or authorized representatives. Such evidence takes into account the benefits, harms and scientific evidence for each treatment option, the use of such care should depend on the informed patient decision aid, and can be easily incorporated into a broad array of practice settings.

(3) PATIENT DECISION AIDS.—Patient decision aids developed and produced pursuant to a grant or contract under paragraph (1)

(a) shall be designed to engage patients, caregivers, and authorized representatives in informed decisionmaking with health care providers;

(b) shall present up-to-date clinical evidence about the risks and benefits of treatment options in a form and manner that is understandable and appropriate for patients, caregivers, and authorized representatives from a variety of cultural and educational backgrounds to reflect the varying values of consumers and diverse levels of health literacy;

(c) shall, where appropriate, explain why there is a lack of evidence to support one treatment option over another; and

(d) shall address health care decisions across the age span, including those affecting vulnerable populations including children.

(4) DISTRIBUTION.—The Director shall ensure that patient decision aids produced with grants or contracts under this section are made available to the public.

(5) NONDUPPLICATION OF EFFORTS.—The Director shall ensure that the activities under
this section of the Agency and other agencies, including the Centers for Disease Control and Prevention and the National Institutes of Health, are free of unnecessary duplication of effort.

"(e) GRANTS TO SUPPORT SHARED DECISION-MAKING IMPLEMENTATION.—

(1) The Secretary shall establish a program to provide for the phased-in development, implementation, and evaluation of shared decisionmaking using patient decision aids to meet the objective of improving the understanding of patients of their medical treatment options.

(2) SHARED DECISION-MAKING RESOURCE CENTERS.—

"(A) IN GENERAL.—The Secretary shall provide grants for the establishment and support of Shared Decisionmaking Resource Centers (referred to in this subsection as 'Centers') to provide technical assistance to providers and to develop and disseminate best practices and other information to support and accelerate adoption, implementation, and effective use of patient decision aids and shared decisionmaking by providers.

"(B) OBJECTIVES.—The objective of a Center is to enhance and promote the dissemination and use of patient decision aids and shared decisionmaking through—

"(i) technical assistance to eligible providers with the implementation and effective use of, and training on, patient decision aids; and

"(ii) the dissemination of best practices and research on the implementation and effective use of patient decision aids.

(3) SHARED DECISION-MAKING PARTICIPATION GRANTS.—

"(A) IN GENERAL.—The Secretary shall provide grants to health care providers for the development and implementation of shared decisionmaking techniques and to assess the use of such techniques.

"(B) PREFERENCE.—In order to facilitate the use of best practices, the Secretary shall provide a preference in making grants under this subsection to health care providers who participate in training by Shared Decisionmaking Resource Centers or comparable training.

"(C) LIMITATION.—Funds under this paragraph shall not be used to purchase or implement patient decision aids other than those certified under the process identified in subsection (c).

"(D) GUIDANCE.—The Secretary may issue guidance to eligible grantees under this section on the use of patient decision aids.

"(E) FUNDING.—For purposes of carrying out this section there are authorized to be appropriated such sums as may be necessary for fiscal year 2010 and each subsequent fiscal year.

SEC. 2007. DEMONSTRATION PROGRAM TO INTEGRATE QUALITY IMPROVEMENT AND PATIENT SAFETY INTO CLINICAL EDUCATION OF HEALTH PROFESSIONALS.

(a) IN GENERAL.—The Secretary may award grants to eligible entities or consortia under this section to carry out demonstration projects to develop and implement academic and curricula that integrate quality improvement and patient safety in the clinical education of health professionals. Such awards shall be made on a competitive basis pursuant to peer review.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity or consortium shall—

(1) agree to provide the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

(2) be or include—

(A) a health professions school;

(B) a school of public health;

(C) a school of social work;

(D) a school of nursing;

(E) a school of pharmacy;

(F) an institution with a graduate medical education program; or

(G) a school of health care administration;

(3) collaborate in the development of curricula described in subsection (a) with an organization that accredits such school or institution;

(4) provide for the collection of data regarding the effectiveness of the demonstration project; and

(5) provide matching funds in accordance with subsection (c).

(c) MATCHING FUNDS.—

(1) IN GENERAL.—The Secretary may award a grant to an entity or consortium under this section only if the entity or consortium agrees to make available non-Federal contributions equal to or exceeding a percentage of the amount of Federal funds provided under the grant.

(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in-kind, fairly evaluated, including equipment or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, or services provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount contributed. Amounts contributed by private sources may be included in determining the amount contributed.

(3) DETERMINATION.—The Secretary shall take such action as may be necessary to evaluate the projects funded under this section and shall report annually to the Committee on Energy and Commerce and the Committee on Education and Labor of the House of Representatives a report that—

(1) describes the specific projects supported under this section; and

(2) contains recommendations for Congress based on the evaluation conducted under subsection (d).

SEC. 2008. IMPROVING WOMEN'S HEALTH.

(a) ESTABLISHMENT OF OFFICE.—There is established within the Office of the Secretary, an Office on Women's Health (referred to in this section as the 'Office').

(b) DUTIES.—The Office shall—

(1) monitor the Department of Health and Human Services' offices, agencies, and regional activities regarding women's health and identity needs regarding the coordination of activities, including intramural and extramural multidisciplinary activities;

(2) provide expert advice and consultation to the Secretary concerning scientific, legal, ethical, and policy issues relating to women's health;

(3) promulgate rules, regulations, and guidelines to improve the exchange of information (including best practices) and to develop and disseminate best practices and other information to support and accelerate adoption, implementation, and effective use of patient decision aids and shared decisionmaking by providers.

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report that provides—

(1) the determination by the Secretary under subsection (a); and

(2) the reasoning and analysis underlying that determination.

(d) AUTHORITY.—If the Secretary determines under subsection (a) that the addition of qualitative summaries of the benefits and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decisionmaking by clinicians and patients and consumers, then the Secretary, not later than 3 years after the date of submission of the report under subsection (c), shall promulgate proposed regulations as necessary to implement such format.

(e) CLARIFICATION.—Nothing in this section shall be construed to restrict the existing authorities of the Secretary with respect to benefit and risk information.

SEC. 2009. FOSTERING EFFECTIVE PATIENT SAFETY TRAINING INTO MEDICAL CURRICULA.

(a) GRANTS TO SUPPORT SHARED DECISION-MAKING IMPLEMENTATION.—

(1) In general.—The Secretary shall provide to individuals or consortiums under this section grants to develop and implement patient decision making strategies to enhance and promote the adoption and use of patient decision aids and shared decisionmaking by providers.

(2) Eligibility.—To be eligible to receive a grant under subsection (a), an entity shall—

(A) agree to provide the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

(B) be or include—

(i) a school of health professions;

(ii) a school of public health;

(iii) a school of social work;

(iv) a school of nursing;

(v) a school of pharmacy;

(vi) a school with a graduate medical education program;

(vii) a school of health care administration;

(viii) an organization that accredits such school or institution;

(3) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(4) GUIDANCE.—The Secretary may issue guidance to eligible grantees under this section on the use of patient decision aids.

(5) FUNDING.—For purposes of carrying out this section there are authorized to be appropriated such sums as may be necessary for fiscal year 2010 and each subsequent fiscal year.

(6) LIMITATION.—Funds under this paragraph shall not be used to purchase or implement patient decision aids other than those certified under the process identified in subsection (c).

(7) GUIDANCE.—The Secretary may issue guidance to eligible grantees under this section on the use of patient decision aids.

(8) FUNDING.—For purposes of carrying out this section there are authorized to be appropriated such sums as may be necessary for fiscal year 2010 and each subsequent fiscal year.
“(1) AUTHORITY.—In carrying out sub-
section (b), the Secretary may make grants
to, and enter into cooperative agreements,
contracts, and interagency agreements with,
public and private entities, agencies, and or-
ganizations.

“(2) EVALUATION AND DISSEMINATION.—The Secretary shall directly or through contracts with public and private entities, agencies, and organizations, provide for evaluations of projects carried out with financial assistance provided under paragraph (1) and for the dis-
semination of information developed as a re-

result of such projects.

“(d) REPORTS.—Not later than 1 year after
the date of enactment of this section, and
every second year thereafter, the Secretary shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under this section during the period for which the report is being prepared.

“(e) AUTHORIZATION OF APPROPRIATIONS.—
For the purpose of carrying out this section, there are authorized to be appropriated such
sums as may be necessary for each of the fiscal
cal years 2010 through 2014.

“(2) TRANSFER OF FUNCTIONS.—There are
transferred to the Office on Women’s Health (established under section 229 of the Public
Health Service Act, as added by this section), all functions exercised by the Office on
Women’s Health of the Public Health Service prior to the establishment of the sec-
tion, including all personnel and compensa-
tion authority, all delegation and assign-
ment authority, and all remaining appro-
riations. All orders, determinations, rules,
regulations, permits, agreements, grants,
contracts, certificates, licenses, registra-
tions, privileges, and other administrative actions that—
(A) have been issued, made, granted, or al-
lowed to become effective by the President,
any Federal agency or official thereof, or by a court of com-
petent jurisdiction, or by operation of law.

(b) CEN

TERS FOR DISEASE CONTROL AND
PREVENTION OFFICE OF WOMEN’S
HEALTH.—Part A of title III of the Public Health
Services Act (42 U.S.C. 291a et seq.) is amended by adding at the end the following:

“SEC. 310A. CENTERS FOR DISEASE
CONTROL AND PREVENTION OFFICE OF
WOMEN’S HEALTH.

“(a) ESTABLISHMENT.—There is established within the Office of the Director of the Cen-
ters for Disease Control and Prevention, an
office to be known as the Office of Women’s Health (referred to in this section as the ‘Of-
fice’), which shall be headed by an Adminis-
tor of the Health Resources and Services Adminis-
tration who shall be appointed by the Director of such Centers.

“(b) PURPOSE.—The Director of the Office shall—

“(1) report to the Director of the Centers for Disease Control and Prevention on the current and emerging health needs of women and, as relevant and appro-
propriate, coordinate with other appropriate of-
fices on activities within the Centers that re-
late to prevention, research, education and
training, service delivery, and policy develop-
ment, for issues of particular concern to
women;

“(2) identify projects in women’s health
that should be conducted or supported by the
Centers;

“(3) consult with health professionals, non-
governmental organizations, consumer organ-
izations, women’s health professionals, and
other individuals and groups, as appropriate,
the policy of the Centers with regard to
women;

“(4) serve as a member of the Department
of Health and Human Services Coordinating
Committee on Women’s Health (established
under section 229(b)(4));

“(c) DEFINITIONS.—In this section, the term ‘women’s health conditions’, with
respect to women of all age, ethnic, and ra-
cial groups, means diseases, disorders, and condi-
tions—

“(1) unique to, significantly more serious
for, or significantly more prevalent in
women; and

“(2) for which the factors of medical risk or
type of medical intervention are different
for women, or for which there is reasonable
evidence that indicates that such factors or
type makes medical intervention necess
ary;

“(d) AUTHORIZATION OF APPROPRIATIONS.—
For the purpose of carrying out this section, there are authorized to be appropriated such
sums as may be necessary for each of the fiscal
cal years 2010 through 2014.

“(e) OFFICE OF WOMEN’S HEALTH RE-
SEARCH.—Section 488(a) of the Public Health
Service Act (42 U.S.C. 277a(a)) is amended by
inserting “and who shall report directly to
the Director” before the period at the end thereof.

“(f) SUBSTANCE ABUSE AND MENTAL
HEALTH SERVICES ADMINISTRATION.—Section 301(f)
(42 U.S.C. 290aa(f)) is amended—

“(1) in paragraph (1), by inserting ‘who
shall report directly to the Administrator’ before the period;

“(2) by redesignating paragraph (4) as para-

graph (5); and

“(3) by inserting after paragraph (3), the fol-

lowing:

“(4) OFFICE.—Nothing in this subsection
shall be construed to preclude the Secretary from exercising the Substance Abuse and Mental Health Administration an
Office of Women’s Health.

“(e) AGENCY FOR HEALTHCARE RESEARCH
AND QUALITY ACTIVITIES REGARDING WOMEN’S
HEALTH.—Part C of title IX of the Public
Health Service Act (42 U.S.C. 299c et seq.) is amended—

“(1) by redesigning sections 925 and 926 as
sections 925 and 927, respectively; and

“(2) by inserting after section 924 the fol-

lowing:

“SEC. 925. ACTIVITIES REGARDING WOMEN’S
HEALTH.

“(a) ESTABLISHMENT.—There is established within the Office of the Director of the Office
of Healthcare and Research Quality, for purposes of this section as an Agency that relate to health care provider training, health service delivery, research, and dem-
onstration projects, for issues of particular
concern to women;

“(b) PURPOSE.—The Office of Healthcare and Research Quality shall—

“(1) report to the Administrator on the current
health status of women, and, as relevant and appro-
priate, coordinate with other appropriate of-
fices on activities within the Office for
research important to women’s health and,
as relevant and appropriate, coordinate with other appropriate offices on activities within the Agency that relate to health services and
effectiveness, for issues of particular concern to
women;

“(2) identify projects in women’s health
that should be conducted or supported by the
Agency;

“(3) consult with health professionals, non-
governmental organizations, consumer organ-
izations, women’s health professionals, and
other individuals and groups, as appropriate,
the Agency policy with regard to women; and

“(4) serve as a member of the Department
of Health and Human Services Coordinating
Committee on Women’s Health (established
under section 229(b)(4)).

“(c) AUTHORIZATION OF APPROPRIATIONS.—
For the purpose of carrying out this section, there are authorized to be appropriated such
sums as may be necessary for each of the fiscal
cal years 2010 through 2014.

“(1) HEALTH RESOURCES AND SERVICES
ADMINISTRATION OFFICE OF WOMEN’S HEALTH.—
Title VII of the Social Security Act (42 U.S.C. 901 et seq.) is amended by adding at the end the following:

“SEC. 713. OFFICE OF WOMEN’S
HEALTH.

“SEC. 713. OFFICE OF WOMEN’S
HEALTH.

“(a) ESTABLISHMENT.—The Secretary shall
establish within the Office of the Adminis-
trator of the Health Resources and Services Administration, an office to be known as the Office of Women’s Health, which shall be headed by a director who shall be appointed by the Administrator.

“(b) PURPOSE.—The Director of the Office shall—

“(1) report to the Administrator on the current
administration level of activity regarding
women’s health across, where appro-
priate, age, biological, and sociocultural con-
texts;

“(2) establish short-range and long-range
goals and objectives within the Health Re-
sources and Services Administration for
women’s health and, as relevant and appro-
priate, coordinate with other appropriate of-
fices on activities within the Office that relate to healthy provider training, health
service delivery, research, and demo-
nstration projects, for issues of particular
concern to women;

“(3) serve as a member of the Department
of Health and Human Services Coordinating
Committee on Women’s Health (established
under section 229(b)(4) of the Public Health
Service Act).

“(c) CONTINUED ADMINISTRATION OF EXIST-
NING PROGRAMS.—The Director of the Office shall assume the authority for the develop-
ment, implementation, administration, and
evaluation of any projects carried out through the Health Resources and Services Administration relating to women’s health on the date of enactment of this section.

“(d) DEFINITIONS.—For purposes of this sec-
tion—

“(1) ADMINISTRATION.—The term ‘Adminis-
tration’ means the Health Resources and Services Administration.

“(2) Office.—The term ‘Office’ means the Office of Women’s Health established under this section in the Administration.
(e) Authorization of Appropriations.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.

(g) Food and Drug Administration Office of Women’s Health.—Chapter X of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 310 et seq.) is amended by adding at the end the following:

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(3) make recommendations to improve Federal efforts relating to prevention, health promotion, public health, and integrative health care practices to ensure Federal efforts are consistent with available standards and evidence.

(b) REPORT.—Not later than July 1, 2010, and annually thereafter through January 1, 2015, the Committee shall submit to the President and the relevant committees of Congress a report that—

(1) describes the activities and efforts on prevention, health promotion, and public health and activities to develop a national strategy conducted by the Council during the period for which the report is prepared;

(2) describes the national progress in meeting specific prevention, health promotion, and public health goals defined in the strategy and any corrective actions recommended by the Council and taken by the relevant agencies and organizations to meet those goals; and

(3) contains a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification (smoking cessation, proper nutrition, appropriate physical health, behavioral health, substance use disorder, and domestic violence screenings) and the prevention measures for the 5 leading disease killers in the United States.

(4) contains specific science-based initiatives to achieve the measurable goals of Healthy People 2010 regarding nutrition, exercise, tobacco cessation, and specific targeting of the 5 leading disease killers in the United States;

(5) contains specific plans for consolidating Federal programs (and Centers that exist to promote healthy behavior and reduce disease risk (including eliminating programs and offices determined to be ineffective in preventing the priority goals of Healthy People 2010);

(6) contains specific plans to ensure that all Federal health care programs are fully coordinated with science-based prevention recommendations by the Director of the Centers for Disease Control and Prevention; and

(7) contains specific plans to ensure that all non-Department of Health and Human Services prevention programs are based on the science-based guidelines developed by the Centers for Disease Control and Prevention under paragraph (2).

(i) PERIODIC REVIEWS.—The Secretary and the Comptroller General of the United States shall jointly conduct periodic reviews, not less than every 5 years, and evaluations of every Federal disease prevention and health promotion initiative, program, and agency. Such reviews shall be evaluated based on effectiveness in meeting metrics-based goals with an analysis posted on such agencies' public Internet websites.

SEC. 3002. PREVENTION AND PUBLIC HEALTH FUND.

(a) PURPOSE.—It is the purpose of this section to establish a Prevention and Public Health Fund (in this section referred to as the ‘‘Fund’’), to be administered through the Department of Health and Human Services, Office of the Secretary, to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.

(b) FUNDING.—There are hereby authorized to be appropriated, and appropriated, to the Fund, such sums as may be necessary for each fiscal year, and the Secretary may, from time to time, and with the approval of the Comptroller General of the United States, transfer funds in the Fund to eligible agencies and programs.

(c) USE OF FUND.—The Secretary shall transfer amounts in the Fund to accounts established under the Public Health Service Act to carry out provisions of the Public Health Service Act to increase funding, over the fiscal year 2008 level, for programs authorized by the Public Health Service Act, for prevention, health promotion, and public health programs, including prevention research and health screenings, such as the Community Transformation grant program, the Education and Outreach Program for Preventive Benefits, and immunization programs.

(d) TRANSFER AUTHORITY.—The Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives may for the transfer of funds in the Fund to eligible activities under this section, subject to subsection (c).

SEC. 3003. CLINICAL AND COMMUNITY PREVENTIVE SERVICES.

(a) PREVENTIVE SERVICES TASK FORCE.—Section 915 of the Public Health Service Act (42 U.S.C. 299a-4) is amended by striking subsection (a) and inserting the following:

"(a) PREVENTIVE SERVICES TASK FORCE.—

(1) ESTABLISHMENT AND PURPOSE.—The Director shall establish a Preventive Services Task Force (referred to in this section as the ‘‘Task Force’’). Such Task Force shall conduct reviews of the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community, and updating previous recommendations, to be published in the Guide to Community Preventive Services Task Force. Such recommendations shall be based on the results of systematic reviews of the scientific and technical evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services, and shall be updated periodically.

(2) DUTIES.—The duties of the Task Force shall include—

(A) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific sub-populations and age groups;

(B) at least once during every 5-year period, review interventions and update recommendations to existing topic areas, including new or improved techniques to assess the health effects of interventions;

(C) improved integration with Federal Government health objectives and related target setting for health improvement;

(D) the enhanced dissemination of recommendations;

(E) the provision of technical assistance to those health care professionals, agencies and organizations that request help in implementing the Guide recommendations; and

(F) reports to Congress and related agencies identifying gaps in research, such as preventive services that receive an insufficient evidence statement. Following up on issues that the Task Force believes are inadequately addressed by current recommendations.

(i) ROLE OF AGENCY.—The Agency shall provide ongoing administrative, research, and technical support to the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring that full time staff resources to those organizations requesting it for implementation of the Guide’s recommendations.

(2) COORDINATION WITH COMMUNITY PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the Community Preventive Services Task Force and the Advisory Committee on Health Information Practices, including the examination of how each task force’s recommendations interact at the nexus of clinic and community.

(3) OPERATION.—Operation. In carrying out the duties under paragraph (2), the Task Force is not subject to the provisions of Appendix 2 of title 5, United States Code.

(4) INDEPENDENCE.—All members of the Task Force convened under this subsection, and any recommendations made by such members, shall be independent and, to the extent practicable, not subject to political pressure.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.

SEC. 3004. COMMUNITY PREVENTIVE SERVICES TASK FORCE.

(a) ESTABLISHMENT AND PURPOSE.—The Director of the Centers for Disease Control and Prevention shall convene an independent Community Preventive Services Task Force (referred to in this section as the ‘‘Task Force’’) to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions for the purpose of developing recommendations, to be published in the Guide to Community Preventive Services Task Force. Such recommendations shall be based on the results of systematic reviews of the scientific and technical evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions, to be published in the Guide, and shall be updated periodically. Such recommendations, to be published in the Guide, shall include—

(A) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific sub-populations and age groups;

(B) at least once during every 5-year period, review interventions and update recommendations to existing topic areas, including new or improved techniques to assess the health effects of interventions;

(C) improved integration with Federal Government health objectives and related target setting for health improvement;

(D) the enhanced dissemination of recommendations;

(E) the provision of technical assistance to those health care professionals, agencies and organizations that request help in implementing the Guide recommendations; and

(F) reports to Congress and related agencies identifying gaps in research, such as preventive services that receive an insufficient evidence statement. Following up on issues that the Task Force believes are inadequately addressed by current recommendations.

(i) ROLE OF AGENCY.—The Agency shall provide ongoing administrative, research, and technical support to the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring that full time staff resources to those organizations requesting it for implementation of the Guide’s recommendations.

(2) COORDINATION WITH COMMUNITY PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the Community Preventive Services Task Force and the Advisory Committee on Health Information Practices, including the examination of how each task force’s recommendations interact at the nexus of clinic and community.

(3) OPERATION.—Operation. In carrying out the duties under paragraph (2), the Task Force is not subject to the provisions of Appendix 2 of title 5, United States Code.

(4) INDEPENDENCE.—All members of the Task Force convened under this subsection, and any recommendations made by such members, shall be independent and, to the extent practicable, not subject to political pressure.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.

"(b) DUTIES.—The duties of the Task Force shall include—

(1) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific sub-populations and age groups, as well as the social, economic and physical environments that can have broad effects on the health and disease disparities among sub-populations and age groups;

(2) at least once during every 5-year period, review interventions and update recommendations to existing topic areas, including new or improved techniques to assess the health effects of interventions;
“(3) improved integration with Federal Government health objectives and related target setting for health improvement;
“(4) the enhanced dissemination of recommendations for preventive services through electronic health information technology, including automatic, consistent reminders for providers and adherence tools for patients;
“(5) the provision of technical assistance to those health care professionals, agencies, and organizations that request help in implementing the recommendations and maintaining the standards and quality of care related to populations and age groups not adequately addressed by current recommendations;
“(6) providing yearly reports to Congress and related agencies identifying gaps in research and recommending priority areas that deserve increased Federal Government attention including gaps related to populations and age groups not adequately addressed by current recommendations;
“(c) ROLE OF AGENCY.—The Director shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of Guide recommendations.
“(d) COORDINATION WITH PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force’s recommendations interact at the nexus of clinical and community.
“(e) OPERATION.—In carrying out the duties under subsection (b), the Task Force shall not be subject to the provisions of Appendix 2 of title 5, United States Code.
“(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.

(2) TECHNICAL AMENDMENTS.—
(A) Section 141 of the Public Health Service Act (as added by section 2 of the ALS Act (Public Law 110-374; 122 Stat. 4047)) is redesignated as section 3 of the Prenatally and Postnatally Diagnosed Conditions Awareness Act (Public Law 110-374; 122 Stat. 4631).
(B) Section 399F of such Act (as added by section 3 of the Prexatile and Postnatally Diagnosed Conditions Awareness Act (Public Law 110-374; 122 Stat. 4631)) is redesignated as section 399S.

SEC. 3004. EDUCATION AND OUTREACH CAMPAIGN REGARDING PREVENTIVE SERVICES

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the “Secretary”) shall provide for the planning, implementation, and coordination of a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span. Such campaign shall include the dissemination of information that—
(1) describes the importance of utilizing preventive services to promote wellness, reduce health disparities, and mitigate chronic disease;
(2) promotes the use of preventive services recommended by the United States Preventive Services Task Force and the Community Preventive Services Task Force;
(3) describes behavioral and lifestyle behaviors linked to the prevention of chronic diseases;
(4) explains the preventive services covered under health plans offered through the American Health Security Program;
(5) describes additional preventive care supported by the Centers for Disease Control and Prevention, the Health Resources and Services Administration (the Substance Abuse and Mental Health Services Administration, the Advisory Committee on Immunization Practices, and other appropriate agencies); and
(6) includes general health promotion information.

(b) CONSULTATION.—In coordinating the campaign under subsection (a), the Secretary shall consult with the Institute of Medicine to provide ongoing advice on evidence-based scientific information, policy, program development, and evaluation.

(c) MEDIA CAMPAIGN.—
(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a science-based media campaign on health promotion and disease prevention.

(2) REQUIREMENT OF CAMPAIGN.—The campaign shall include—
(A) be designed to address proper nutrition, regular exercise, smoking cessation, obesity reduction, the 5 leading disease killers in the United States, and secondary prevention through disease screening promotion;
(B) shall be carried out through competitively bid contracts awarded to entities providing for the professional production and design of such campaign;
(C) may include the use of radio, television, print, Internet, and social media marketing venues and may be targeted to specific age groups based on peer-reviewed social research;
(D) shall not be duplicative of any other Federal efforts relating to health promotion and disease prevention; and
(E) may include the use of humor and nationally recognized models.

(3) EVALUATION.—The Secretary shall ensure that the campaign implemented under paragraph (1) is subject to an independent evaluation every 2 years and shall report every 2 years to Congress on the effectiveness of such campaigns towards meeting science-based metrics.

(d) WEBSITE.—The Secretary, in consultation with private-sector experts, shall maintain or enter into a contract to maintain an Internet website to provide science-based information on guidelines for nutrition, regular exercise, obesity reduction, smoking cessation, and specific chronic disease prevention. Such website shall be designed to provide information to health care providers and consumers.

(e) DISSEMINATION OF INFORMATION THROUGH PROGRAMS.—The Secretary, acting through the Centers for Disease Control and Prevention, shall develop and implement a plan for the dissemination of health promotion and disease prevention information consistent with national priorities, to health care providers who participate in Federal programs, including programs administered by the Indian Health Service, the Department of Veterans Affairs, the Department of Defense, and the Health Resources and Services Administration.

(f) PERSONALIZED PREVENTION PLANS.—
(1) CONTRACT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, as specified by the Secretary, shall enter into a contract with a qualified entity for the development and operation of a Federal Internet website personalized prevention plan tool.

(2) USE.—The website developed under paragraph (1) shall be designed to be used as a source of the most up-to-date scientific evidence relating to other prevention for use by individuals. Such website shall contain a component that enables an individual to determine their disease risk (based on personal health conditions, race/ethnicity, and other relevant information) relating to the 5 leading diseases in the United States, and obtain personalized suggestions for prevention efforts.

(g) INTERNET PORTAL.—The Secretary shall establish an Internet portal for accessing risk-assessment tools developed and maintained by private and academic entities.

(h) PRIORITY FUNDING.—Funding for the activities authorized under this section shall take priority over funds provided through the Centers for Disease Control and Prevention for grants to States and other entities for similar purposes and goals as provided for in this section. Not to exceed $50,000,000 shall be expended on the campaigns and activities required under this section.

(i) PUBLIC AWARENESS OF PREVENTIVE AND OBESITY-RELATED SERVICES.—
(1) INFORMATION TO STATES.—The Secretary of Health and Human Services shall provide guidance and relevant information to States and other health care providers relating to preventive and obesity-related services that are available through the American Health Security Program.

(2) DISTRIBUTION TO ENROLLERS.—Each State shall design a public awareness campaign regarding availability and coverage of such services, with the goal of reducing incidences of obesity.

(3) REPORT.—Not later than January 1, 2011, and every 3 years thereafter through December 31, 2013, the Health and Human Services shall report to Congress on the status and effectiveness of efforts under paragraphs (1) and (2), including summaries of States’ efforts to increase the awareness of coverage of obesity-related services.

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

Subtitle B—Increasing Access to Clinical Preventive Services

SEC. 3101. SCHOOL-BASED HEALTH CENTERS

(a) GRANTS FOR THE ESTABLISHMENT OF SCHOOL-BASED HEALTH CENTERS

(1) PROGRAM.—The Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) shall establish a program to award grants to eligible entities to support the operation of school-based health centers.

(2) ELIGIBILITY.—To be eligible for a grant under this subsection, an entity shall—
(A) be a school-based health center or a sponsoring facility of a school-based health center; and
(B) submit an application at such time, in such manner, and containing such information as the Secretary may require, including an estimate of the number of students likely to be served, a description of the type and scope of services provided, an outlined plan for the dissemination of health promotion and disease prevention information consistent with national priorities, to health care providers who participate in Federal programs, including programs administered by the Indian Health Service, the Department of Veterans Affairs, the Department of Defense, and the Health Resources and Services Administration;

(3) LIMITATION ON USE OF FUNDS.—An eligible entity shall use funds provided under a grant awarded under this subsection only for expenditures for facilities (including the acquisition or improvement of land, or the acquisition, construction, expansion, replacement, or other improvement of any building or other facility), equipment, or similar expenditures, consistent with national priorities, to health care providers who participate in Federal programs, including programs administered by the Indian Health Service, the Department of Veterans Affairs, the Department of Defense, and the Health Resources and Services Administration;

(4) A PPROPRIATIONS.—Out of any funds appropriated for similar purposes and goals as provided for in this section. Not to exceed $500,000,000 for similar purposes and goals as provided for in this section. Not to exceed $500,000,000 for similar purposes and goals as provided for in this section.

(h) PRIORITY FUNDING.—Funding for the activities authorized under this section shall take priority over funds provided through the Centers for Disease Control and Prevention for grants to States and other entities for similar purposes and goals as provided for in this section. Not to exceed $50,000,000 shall be expended on the campaigns and activities required under this section.

(i) PUBLIC AWARENESS OF PREVENTIVE AND OBESITY-RELATED SERVICES.—
(1) INFORMATION TO STATES.—The Secretary of Health and Human Services shall provide guidance and relevant information to States and other health care providers relating to preventive and obesity-related services that are available through the American Health Security Program.

(2) DISTRIBUTION TO ENROLLERS.—Each State shall design a public awareness campaign regarding availability and coverage of such services, with the goal of reducing incidences of obesity.

(3) REPORT.—Not later than January 1, 2011, and every 3 years thereafter through December 31, 2013, the Health and Human Services shall report to Congress on the status and effectiveness of efforts under paragraphs (1) and (2), including summaries of States’ efforts to increase the awareness of coverage of obesity-related services.

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

Title III—Part Q of title III of the Public Health Service Act (42 U.S.C. 233(q))
shall include the following:

(A) PHYSICAL.—Comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions, and follow-up for, specialty care and oral health services.

(B) MENTAL HEALTH.—Mental health and substance use disorder assessments, crisis intervention, treatment, and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs.

(2) MEDICALLY UNDERSERVED CHILDREN AND ADOLESCENTS.—

(A) IN GENERAL.—The term ‘medically underserved children and adolescents’ means a population of children and adolescents who are residents of an area designated as a medically underserved area or a health professional shortage area, by the Secretary.

(B) CRITERIA.—The Secretary shall prescribe criteria for determining the specific shortage of personal health services for medically underserved children and adolescents under subparagraph (A) that shall—

(i) take into account any comments received by the Secretary from the chief executive officer of a State and local officials in a State; and

(ii) include factors indicative of the health status of such children and adolescents of an area, the accessibility of health services, the availability of health professionals to such children and adolescents, and other factors as determined appropriate by the Secretary.

(3) SCHOOL-BASED HEALTH CENTER.—The term ‘school-based health center’ means—

(A) meets the definition of a school-based health center under section 2110(c)(9)(A) of the Social Security Act and is administered by a sponsoring entity (as defined in section 2110(c)(9)(B) of the Social Security Act);

(B) provides, at a minimum, comprehensive primary health services during school hours to adolescents and children in accordance with established standards, community practice, reporting laws, and other State laws, including parent/teacher conferences, in a manner consistent with Federal law; and

(C) does not perform abortion services.

(b) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants for the costs of the operation of school-based health centers (referred to in this section as ‘SBHCs’) that meet the requirements of this section.

(c) ACTORS.—To be eligible to receive a grant under this section, an entity shall—

(1) be an SBHC (as defined in subsection (a)(3));

(2) submit to the Secretary an application at such time, in such manner, and containing—

(A) evidence that the applicant meets all criteria necessary to be designated an SBHC;

(B) evidence of local need for the services to be provided by the SBHC;

(C) a description of services to be provided by the SBHC;

(D) (i) services will be provided to those children and adolescents for whom parental or guardian consent has been obtained in accordance with Federal, State, and local laws governing health care service provision to children and adolescents;

(ii) the SBHC has made and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area;

(iii) the SBHC will provide on-site access during the academic day when school is in session and 24-hour coverage through an on-call system to obtain health care providers to ensure access to services on a year-round basis when the school or the SBHC is closed;

(iv) the SBHC will be integrated into the school environment and will coordinate health services with school personnel, such as administrators, counselors, social workers, and support personnel, as well as with other community providers co-located at the school;

(v) the SBHC sponsoring facility assumes all responsibility for the SBHC administration, operations, and oversight; and

(vi) the SBHC will comply with Federal, State, and local laws concerning patient privacy and student records, including regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 444 of the General Education Provisions Act; and

(D) other such information as the Secretary may require.

(d) PREFERENCES AND CONSIDERATION.—In reviewing applications:

(1) The Secretary may give preference to applicants that demonstrate an ability to serve the following:

(A) Communities that have evidenced barriers to primary health care and mental health and substance use disorder prevention services for children and adolescents.

(B) Populations of children and adolescents that have historically demonstrated difficulty in accessing health and mental health and substance use disorder prevention services.

(2) The Secretary may give consideration to whether an applicant has received a grant under subsection (a) of section 3101 of the Patient Protection and Affordable Care Act.

(e) WAIVER OF REQUIREMENTS.—The Secretary may—

(1) under appropriate circumstances, waive the application of all or part of the requirements of this subsection with respect to an SBHC for not to exceed 2 years; and

(2) upon a showing of good cause, waive the requirement that the SBHC provide all required comprehensive primary health services for a designated period of time to be determined by the Secretary.

(f) USE OF FUNDS.—

(1) Federal funds awarded under a grant under this section—

(a) may be used for—

(i) acquiring and leasing equipment (including transportation equipment) to carry out the activities supported by the grant; and

(ii) providing training related to the provision of required comprehensive primary health services and additional health services;

(iii) the management and operation of health center programs;

(iv) the payment of salaries for physicians, nurses, and other personnel of the SBHC; and

(B) may not be used to provide abortions.

(2) CONSTRUCTION.—The Secretary may award grants which may be used to pay the costs associated with expanding and modernizing existing buildings for use as an SBHC, including the purchase of trailers or manufactured buildings to install on the school property.

(g) LIMITATIONS.—

(A) IN GENERAL.—Any provider of services that is determined by a State to be in violation of a State law described in subsection (a)(3)(B) with respect to activities carried out at a SBHC shall not be eligible to receive additional funding under this section.

(B) NO OVERLAPPING.—No entity that has received funding under section 330 for a grant period shall be eligible for a grant under this section for with respect to the same grant period.

(g) MATCHING REQUIREMENT.—

(1) IN GENERAL.—Each eligible entity that receives a grant under this section shall provide, from non-Federal sources, an amount equal to 20 percent of the amount of the grant (which may be provided in cash or in-kind) to carry out the activities supported by the grant.

(2) WAIVER.—The Secretary may waive all or part of the matching requirement described in paragraph (1) for any fiscal year for the SBHC if the Secretary determines that applying the matching requirement to the SBHC would result in serious hardship or an inability to carry out the purposes of this section.

(h) SUPPLEMENT, NOT SUPPLANT.—Grant funds provided under this section shall be used to supplement, not supplant, other Federal or State funds.

(i) EVALUATION.—The Secretary shall develop, implement, and evaluate SBHCs and monitoring quality performance under the awards made under this section.

(j) ADMINISTRATION.—An eligible entity receiving funds under this section shall only provide age appropriate services through a SBHC funded under this section to an individual.

(k) PARENTAL CONSENT.—An eligible entity receiving funds under this section shall not provide services through a SBHC funded under this section to an individual without the consent of the parent or guardian of such individual.

(l) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.

SEC. 3102. ORAL HEALTHCARE PREVENTION ACTIVITIES.

(a) IN GENERAL.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

PART T—ORAL HEALTHCARE PREVENTION ACTIVITIES.

SEC. 399LL. ORAL HEALTHCARE PREVENTION EDUCATION CAMPAIGN.

(a) ESTABLISHMENT.—The Secretary, acting through the Director, shall establish and conduct a campaign, to be known as the ‘Healthy Bites—Smart Choices—Smart Smiles’ campaign (referred to in this section as ‘campaign’), for the purpose of educating the public and building public support for increased prevention efforts within the oral health field. The campaign shall focus on preventing oral disease and providing information about oral health education, including prevention of oral disease such as early childhood and other caries, periodontal disease, and oral cancer.

(b) REQUIREMENTS.—To be eligible to participate in the campaign, the Secretary shall—

(1) ensure that activities are targeted toward at-risk populations, such as children, pregnant women, parents, the elderly, individuals with disabilities, and ethnic and racial minority populations, including Indians, Alaska Natives and Native Hawaiians as defined in section 3(c) of the Maternal and Child Health Improvement Act) in a culturally and linguistically appropriate manner; and

(2) authorize the Secretary to develop and carry out activities to convey oral health prevention messages that include, but are not limited to, community water fluoridation and dental sealants.
begin implementing the 5-year campaign. During the 2-year period referred to in the previous sentence, the Secretary shall conduct planning activities with respect to the community transformation plan.

SEC. 399LL-1. RESEARCH-BASED DENTAL CARIES DISEASE MANAGEMENT.

(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award demonstration grants to eligible entities to demonstrate the effectiveness of research-based dental caries disease management activities.

(b) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall—

(1) be a community-based provider of dental services (as defined by the Secretary), including a Federally-qualified health center, a clinic, or other facility, and owned or operated by a State (or by an instrumentality or a unit of government within a State), a State or local department of health, a dental program of the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act, 2000); or

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) USE OF FUNDS.—A grantee shall use amounts received under a grant under this section to—

(1) demonstrate the effectiveness of research-based dental caries disease management activities; and

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

SEC. 399LL-2. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated to carry out this part, such sums as may be necessary.

(b) SCHOOL-BASED SEALANT PROGRAMS.—Section 317M(c)(1) of the Public Health Service Act (42 U.S.C. 300g-25) is amended by inserting “may award grants to States and Indian tribes” and inserting “shall award a grant to each of the 50 States and territories and tribal organizations, urban Indian organizations and urban Indian organizations (as such terms are defined in section 4 of the Indian Health Care Improvement Act)’’.

(c) ORAL HEALTH INFRASTRUCTURE.—Section 317M of the Public Health Service Act (42 U.S.C. 247b-14) is amended by—

(1) redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (c), the following:

“(d) COOPERATIVE AGREEMENTS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into cooperative agreements with State, territorial, and Indian tribes or tribal organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act), to establish oral health leadership and program guidance, oral health data collection and interpretation, (including determinants of poor oral health among vulnerable populations); and

(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as necessary to carry out this subsection for fiscal years 2010 through 2014.”

(d) UPDATING NATIONAL ORAL HEALTHCARE SURVEILLANCE ACTIVITIES.

(1) PRAMS.—(A) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the “Secretary”), acting through the Director of the Centers for Disease Control and Prevention (referred to in this section as “PRAMS”) and as appropriate infrastructure necessary to engage key stakeholders from multiple sectors within and beyond health care and assist communities in linking futures corps and health care providers.

(b) USE OF FUNDS.—(1) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to carry out programs described in this subsection.

(2) COMMUNITY TRANSFORMATION PLAN.—(A) IN GENERAL.—An eligible entity that receives a grant under this section shall submit to the Director (for approval) a detailed plan that includes the policy, environmental, programmatic, and as appropriate infrastructure changes needed to promote healthy living and reduce disparities.

(B) ACTIVITIES.—Activities within the plan may focus on (but not be limited to)—

(1) creating the infrastructure to support healthy living and access to nutritious foods in a safe environment;

(ii) changes in tobacco use prevalence;

(iii) assessing and implementing worksite wellness programming and incentives;

(iv) working to highlight healthy options at restaurants and other food venues;

(v) prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health; and

(vi) addressing special populations needs, including all age groups and individuals with disabilities, and individuals in both urban and rural areas.

(3) COMMUNITY-BASED PREVENTION HEALTH ACTIVITIES.—

(A) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to implement a variety of programs, policies, and infrastructure improvements to promote healthier lifestyles.

(B) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be—

(2) submit to the Secretary a report concerning activities conducted within the State under PRAMS.

(3) MEASUREMENTS.—The oral healthcare measurements developed by the Secretary for use under PRAMS shall be mandatory with respect to States for purposes of the State reports under clause (1).

(C) FUNDING.—There is authorized to be appropriated to carry out this paragraph, such sums as may be necessary.

(2) NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY.—The Secretary shall develop oral health components that shall include tooth-level surveillance for inclusion in the National Health and Nutrition Examination Survey. Such components shall be updated every 5 years.

(3) MEDICARE PANEL SURVEY.—The Secretary shall ensure that the Medical Expenditures Panel Survey by the Agency for Healthcare Research and Quality includes the verification of dental surface, expenditure, and coverage findings through conduct of a look-back analysis.

(4) NATIONAL ORAL HEALTH SURVEILLANCE SYSTEM.—(A) APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary for each of fiscal years 2010 through 2014 for—

(i) the oral health surveillance system to conduct activities to measure the prevalence of dental sealants and community water fluoridation); to improve dental health; and

(ii) the community health; and

(B) REQUIREMENTS.—The Secretary shall ensure that the National Oral Health Surveillance System includes the measurement of early childhood caries.

Subtitle C—Creating Healthier Communities

SEC. 399LL-3. COMMUNITY TRANSFORMATION GRANTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”), acting through the Director of the Centers for Disease Control and Prevention (referred to in this section as “CDC”), shall make grants to eligible entities to support implementation of the public education campaign under section 399LL.

(b) ELIGIBILITY.—To be eligible for a grant under this section to carry out programs described in this subsection, a grantee shall—

(C) FUNDING.—There is authorized to be appropriated, such sums as may be necessary.

(1) IN GENERAL.—A grantee shall use amounts received under a grant under this section to—

(ii) a description of the program to be carried out under the grant; and

(iii) demonstrate the need for the program to be carried out under the grant.

(b) REQUIREMENTS.—The Secretary shall ensure that the program to be carried out under a grant satisfies the requirements for the program.

(2) COMMUNITY TRANSFORMATION PLAN.—(A) IN GENERAL.—An eligible entity that receives a grant under this section shall submit to the Director (for approval) a detailed plan that includes the policy, environmental, programmatic, and as appropriate infrastructure changes needed to promote healthy living and reduce disparities.

(B) ACTIVITIES.—Activities within the plan may focus on (but not be limited to)—

(1) developing and promoting programs targeting a variety of age levels to increase access to nutrition, physical activity and smoking cessation, improve social and emotional wellness, enhance safety in a community, or address any other chronic disease priority area identified by the grantee.

(iv) assessing and implementing worksite wellness programming and incentives;

(v) working to highlight healthy options at restaurants and other food venues;

(vi) prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health; and

(vii) addressing special populations needs, including all age groups and individuals with disabilities, and individuals in both urban and rural areas.

(3) COMMUNITY-BASED PREVENTION HEALTH ACTIVITIES.—

(A) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to—

(B) REQUIREMENTS.—An eligible entity may provide in-kind resources such as staff, equipment, or office space in carrying out activities under this section.

(4) EVALUATION.—(A) IN GENERAL.—An eligible entity shall—

(B) TYPES OF MEASURES.—In carrying out subsection (A), the eligible entity shall—

(i) changes in weight;

(ii) changes in smoking prevalence;

(iii) changes in physical activity; and

(iv) changes in tobacco use prevalence;
(v) changes in emotional well-being and overall mental health;
(vi) other factors using community-specific data from the Behavioral Risk Factor Surveillance System.
(vii) other factors as determined by the Secretary.
(C) REPORTING.—An eligible entity shall annually submit to the Director a report containing an evaluation of activities carried out under the grant.
(D) DISSEMINATION.—A grantee under this section shall—
(1) meet at least annually in regional or national meetings to discuss challenges, best practices, and lessons learned with respect to activities conducted under the grant; and
(2) develop models for the replication of successful programs and activities and the mentoring of other eligible entities.
(e) TRAINING.—(1) IN GENERAL.—The Director shall develop a program to provide training for eligible entities on effective strategies for the prevention and control of chronic disease and the link between physical, emotional, and social well-being.
(f) COMMUNITY TRANSFORMATION PLAN.—The Director shall provide adequate feedback and technical assistance to grantees to establish community transformation plans.
(g) DETAILED IMPLEMENTATION REQUIREMENTS.—The Director shall provide a literature review and framework for the evaluation of programs conducted as part of the grant program under this section. In addition to working with academic institutions or other entities with expertise in outcome evaluation.
(h) PROHIBITION.—A grantee shall not use funds provided under a grant under this section to create video games or to carry out any other activities that may lead to higher rates of obesity or inactivity.
(i) APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each fiscal years 2010 through 2014.

SEC. 3202. HEALTHY AGING, LIVING WELL; EVALUATION OF COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS.

(a) HEALTHY AGING, LIVING WELL.—
(1) PROGRAM.—The Secretary of Health and Human Services (referred to in this section as the ‘‘Secretary’’), acting through the Director of the Centers for Disease Control and Prevention, shall award through a State or local health department and Indian tribes to carry out 5-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age.
(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), an entity shall—
(A) be—
(i) a State health department;
(ii) a local health department; or
(iii) an Indian tribe
(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require including a description of the program to be carried out under the grant;
(C) design a strategy for improving the health of the 55-to-64 year-old population through community-based public health interventions; and
(D) demonstrate the capacity, if funded, to develop the relationships necessary with relevant health care providers, community-based organizations, and insurers to carry out the activities described in paragraph (3), such relationships to include the identification of a community partner, such as a community health center or rural health clinic.
(3) USE OF FUNDS.—
(A) IN GENERAL.—A State or local health department shall use amounts received under a grant under this subsection to carry out activities described in this paragraph to individuals who are between 55 and 64 years of age.
(B) PUBLIC HEALTH INTERVENTIONS.—
(i) IN GENERAL.—In general and implementing such activities, a grantee shall collaborate with the Centers for Disease Control and Prevention and the Administration on Aging, and relevant local agencies and organizations.
(ii) TYPES OF INTERVENTION ACTIVITIES.—
(A) IN GENERAL.—Intervention activities conducted under this subparagraph may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyle changes among the target population.
(B) EVALUATION.—The evaluation under this subparagraph may include—
(I) mental health/behavioral health and substance use care;
(II) physical activity, smoking, and nutrition; and
(III) any other measures deemed appropriate by the Secretary.
(iii) MONITORING.—Grantees under this section shall maintain records of screening results under this subsection to establish the baseline data for monitoring the targeted population.
(D) CLINICAL REFERRAL/TREATMENT FOR CHRONIC DISEASES.—
(1) IN GENERAL.—A State or local health department shall use amounts received under a grant under this subsection to conduct ongoing health screening to identify risk factors for disease such as cancer, stroke, and diabetes among individuals in both urban and rural areas who are between 55 and 64 years of age.
(2) TYPES OF INTERVENTION ACTIVITIES.—Screening activities conducted under this subparagraph may include—
(I) health/behavioral health and substance use care;
(II) falls; and
(III) chronic disease self-management.
(E) Grantee Evaluation.—An eligible entity shall use amounts provided under a grant under this subsection to conduct activities to measure changes in the prevalence of chronic disease risk factors among participants.
(F) Pilot Program Evaluation.—The Secretary shall conduct an annual evaluation of the effectiveness of the pilot program under this subsection. In determining such effectiveness, the Secretary shall consider changes in the prevalence of uncontrolled chronic disease risk factors among individuals who are 65 years of age and older who reside in the States and localities receiving grants under this section as compared with national and historical data for those States and localities for the same population.
(G) Community Transformation Plan.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2014.
(b) EVALUATION AND PLAN FOR COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS.—
(1) IN GENERAL.—The Secretary shall conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for individuals who are 65 years of age and older.
(2) EVALUATION.—The evaluation under this subsection shall consist of the following:
(I) EVIDENCE REVIEW.—The Secretary shall review available evidence of best practices, and resources that are relevant to programs that promote healthy lifestyles and reduce risk factors for individuals who are 65 years of age and older. The Secretary may determine the evidence review and such issues to be considered, which shall include, at a minimum—
(I) physical activity, nutrition, and obesity;
(II) falls;
(III) chronic disease self-management; and
(IV) mental health.
(II) INDEPENDENT EVALUATION OF EVIDENCE-BASED COMMUNITY PREVENTION AND WELLNESS PROGRAMS.—The Assistant Secretary for Aging, shall, to the extent feasible and practicable, conduct an evaluation of existing community prevention and wellness programs that are sponsored by the Administration on Aging to assess the extent to which individuals who are 65 years of age and older participate in such programs.
(III) USE OF FUNDS.—
(A) Grants transferred under the preceding paragraphs may include—
(B) IN GENERAL.—The Secretary shall—
(I) IN GENERAL.—In developing and implementing such activities, a grantee shall collaborate with such other public programs.
(ii) a local health department; or
(iii) an Indian tribe

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Amendment—Chapter 33 of title 44, United States Code shall not apply to the

This subsection.
SEC. 3205. NUTRITION LABELING OF STANDARD MENU ITEMS AT CHAIN RESTAURANTS.

(a) TECHNICAL AMENDMENTS.—Section 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)(A)) is amended—

(1) in subitem (i), by inserting at the beginning “except as provided in clause (H)(III),” and

(2) in subitem (ii), by inserting at the beginning “except as provided in clause (H)(III),”.

(b) LABELING REQUIREMENTS.—Section 403(q)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)) is amended by adding at the end the following:

(1) IN GENERAL.—Except as provided in subclause (v), a restaurant may be associated with a standard menu item that is offered for sale in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items, the restaurant shall disclose the information described in subclauses (ii) and (iii).

(2) INFORMATION REQUIRED TO BE DISCLOSED BY RESTAURANTS AND RETAIL FOOD ESTABLISHMENTS.—Except as provided in subclause (vii), the restaurant or similar retail food establishment shall disclose in a clear and conspicuous manner—

(I)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, on the menu listing the item for sale, the number of calories contained in the standard menu item, and any other information required under the standard menu item, on the menu listing the item for sale, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu and designed to enable the public to understand, in the context of a total daily diet, the significance of the caloric information that is provided on the menu board.

(2)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu listing the item for sale, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu and designed to enable the public to understand, in the context of a total daily diet, the significance of the nutrition information that is provided on the menu board.

(III) in a written form, available on the premises of the restaurant or similar retail establishment and to the consumer upon request, the nutrition information required under clauses (C) and (D) of subparagraph (1); and

(IV) on the menu or menu board, a prominent symbol, and conspicuous statement regarding the availability of the information described in item (III).

(III) SELF-SERVICE FOOD AND FOOD ON DISPLAY.—Except as provided in paragraph (vii), in the case of food sold at a salad bar, buffet line, cafeteria line, or similar self-service facility, and for self-service beverages or food products displayed for sale to customers, a restaurant or similar retail food establishment shall place adjacent to each

VACCINES FOR ADULTS.—

(a) STATE AUTHORITY TO PURCHASE RECOMMENDED VACCINES FOR ADULTS.—Section 317 of the Public Health Service Act (42 U.S.C. 247b) is amended by adding at the end the following:

(1) AUTHORITY TO PURCHASE RECOMMENDED VACCINES FOR ADULTS.—

(1) in general.—The Secretary may negotiate and enter into contracts with manufacturers of vaccines for the purchase and delivery of vaccines for adults as provided for under subsection (e).

(2) STATE PURCHASE.—A State may obtain additional quantities of such adult vaccines (subject to amounts specified to the Secretary by the State in advance of negotiations) through the purchase of vaccines from manufacturers at the applicable price negotiated by the Secretary by regulation and posted, in a clear, and conspicuous statement relevant to the consumer upon request, the availability of such information.

(2)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, on the menu listing the item for sale, the number of calories contained in the standard menu item, and any other information required under the standard menu item, so as to be clearly associated with the standard menu item, on the menu listing the item for sale, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu and designed to enable the public to understand, in the context of a total daily diet, the significance of the caloric information that is provided on the menu board.

(III) SELF-SERVICE FOOD AND FOOD ON DISPLAY.—Except as provided in paragraph (vii), in the case of food sold at a salad bar, buffet line, cafeteria line, or similar self-service facility, and for self-service beverages or food products displayed for sale to customers, a restaurant or similar retail food establishment shall place adjacent to each

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food offered a sign that lists calories per displayed food item or per serving.

(iv) Reasonable Basis.—For the purposes of this clause, a restaurant or similar retail food establishment shall have a reasonable basis for its nutrient content disclosures, including nutrient databases, cookbooks, laboratory analyses, and other reasonable means of ascertaining the nutrient content of food sold from vending machines.

(v) Voluntary Provision of Nutrition Information.—

(1) In General.—An authorized official of any restaurant or similar retail food establishment or vending machine operator not subject to the requirements of this clause, may elect to be subject to the requirements of such clause, by registering biannually the name and address of such restaurant or similar retail food establishment or vending machine operator with the Secretary, as specified by the Secretary by regulation.

(2) Registration.—Within 120 days of enactment, the Secretary shall publish a notice in the Federal Register specifying the terms and conditions for implementation of this item, pending promulgation of the regulations.

(III) Rule of Construction.—Nothing in this subclause shall be construed to authorize the Secretary to require an application, review, or licensing process for any entity to register with the Secretary, as described in such item.

(II) Contents.—In promulgating regulations, the Secretary shall:

(aa) consider standardization of recipes and methods of preparation, reasonable variation in serving size and formulation of menu items, space on menus and menu boards, inadvertent human error, training of food service workers, variations in ingredients, and other factors, as the Secretary determines; and

(bb) specify the format and manner of the nutrient content disclosure requirements under this subclause.

(III) Reporting.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a quarterly report that describes the Secretary's progress towards promulgating final regulations under this subparagraph.

(xi) Definition.—In this clause, the term ‘menu’ or ‘menu board’ means the primary writing on the menu of a restaurant or similar retail food establishment from which a consumer makes an order selection.

(II) Written Forms.—Subparagraph (5)(C) shall apply to any regulations promulgated under subparagraph (I)(III) and (vi).

(viii) Vending Machines.—

(1) In General.—In the case of an article of food displayed by a vending machine that:

(aa) does not permit a prospective purchaser to examine the Nutrition Facts Panel before purchasing the article or does not otherwise provide visible nutrition information at the point of purchase; and

(bb) is operated by a person who is engaged in the business of owning or operating 20 or more vending machines, the vending machine operator shall provide a sign in close proximity to each article of food or the selection button that includes a clear and conspicuous statement disclosing the number of calories contained in the article.

(IX) Voluntary Provision of Nutrition Information.—

(1) In General.—An authorized official of any restaurant or similar retail food establishment or vending machine operator not subject to the requirements of this clause may elect to be subject to the requirements of such clause, by registering biannually the name and address of such restaurant or similar retail food establishment or vending machine operator with the Secretary, as specified by the Secretary by regulation.

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(II) Registration.—Within 120 days of enactment, the Secretary shall publish a notice in the Federal Register specifying the terms and conditions for implementation of this item, pending promulgation of the regulations.

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(bb) specify the format and manner of the nutrient content disclosure requirements under this subclause.

(III) Reporting.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a quarterly report that describes the Secretary's progress towards promulgating final regulations under this subparagraph.

(II) Written Forms.—Subparagraph (5)(C) shall apply to any regulations promulgated under subparagraph (I)(III) and (vi).

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(bb) is operated by a person who is engaged in the business of owning or operating 20 or more vending machines, the vending machine operator shall provide a sign in close proximity to each article of food or the selection button that includes a clear and conspicuous statement disclosing the number of calories contained in the article.

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(II) Registration.—Within 120 days of enactment, the Secretary shall publish a notice in the Federal Register specifying the terms and conditions for implementation of this item, pending promulgation of the regulations.

(III) Rule of Construction.—Nothing in this subclause shall be construed to authorize the Secretary to require an application, review, or licensing process for any entity to register with the Secretary, as described in such item.
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(1) examining evidence-based practices relating to prevention, with a particular focus on high priority areas as identified by the Secretary in the National Prevention Strategy for 2010, and including comparing community-based public health interventions in terms of effectiveness and cost;

(2) analyzing the translation of interventions from academic settings to real world settings and

(3) identifying effective strategies for organizing, financing, or delivering public health services in real world community settings, including comparing State and local health department programs and systems in terms of effectiveness and cost.

(c) EXISTING PARTNERSHIPS.—Research supported under this section shall be coordinated with the Community Preventive Services Task Force and carried out by building on existing partnerships within the Federal Government while also considering initiatives at the State and local levels and in the private sector.

(d) ANNUAL REPORT.—The Secretary shall, on an annual basis, submit to Congress a report concerning the activities and findings with respect to research supported under this section.

SEC. 3302. UNDERSTANDING HEALTH DISPARITIES: DATA COLLECTION AND ANALYSIS

(a) UNIFORM CATEGORIES AND COLLECTION REQUIREMENTS.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

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how to evaluate employer-based wellness programs by ensuring evaluation resources, technical assistance, and consultation are available to workplace staff as needed through multiple dissemination channels such as web portals, call centers, or other means.

**SEC. 399MM-1. NATIONAL WORKSITE HEALTH POLICIES AND PROGRAMS STUDY.**

(a) In General.—To assess, analyze, and monitor over time data about workplace policies and programs, and to develop instruments to assess and evaluate comprehensive workplace chronic disease prevention and health promotion programs, policies and practices, not later than 2 years after the date of enactment of this part, and at regular intervals (to be determined by the Director) thereafter, the Director shall conduct a national worksite health policies and programs survey to assess employer-based health policies and programs.

(b) Report.—Upon the completion of each study under subsection (a), the Director shall submit to Congress a report that includes the recommendations of the Director for the implementation of effective employer-based health policies and programs.

**SEC. 399MM-2. PRIORITYIZATION OF EVALUATION BY SECRETARY.**

The Secretary shall evaluate, in accordance with this part, all programs funded through the Centers for Disease Control and Prevention that are conducting such evaluation of privately funded programs unless an entity with a privately funded wellness program requests such an evaluation.

**SEC. 399MM-3. PROHIBITION OF FEDERAL WORKPLACE WELLNESS REQUIREMENTS.**

Notwithstanding any other provision of this part, any recommendations, data, or assessments carried out under this part shall not be used to mandate requirements for workplace wellness programs.

**SEC. 3.304. EPIDEMIOLOGY-LABORATORY CAPACITIES GRANTS.**

Title XXVIII of the Public Health Service Act (42 U.S.C. 300hh et seq.) is amended by adding at the end the following:

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Subtitle C—Strengthening Public Health Surveillance Systems

SEC. 2821. EPIDEMIOLOGY-LABORATORY CAPACITIES GRANTS.

(a) In General.—Subject to the availability of appropriations, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an Epidemiology and Laboratory Capacity Grant Program to award grants to State health departments as well as local health departments and tribal jurisdictions that meet such criteria as the Director determines appropriate. Academic centers that assist State and eligible local and tribal health departments may also be eligible for funding under this section as the Director determines appropriate. Grants shall be awarded under this section to assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance by:

(1) strengthening epidemiologic capacity to identify and monitor the occurrence of infectious diseases and other conditions of public health importance;

(2) enhancing laboratory practice as well as systems to report test results and orders electronically;

(3) improving information systems including maintaining an information exchange using national guidelines and complying with capacities and functions determined by an advisory council established by the Director of the Centers for Disease Control and Prevention; and

(4) developing and implementing prevention and control strategies.

(b) Authorization of Appropriations.—There are authorized to be appropriated to carry out this section $190,000,000 for each of fiscal years 2010 through 2013, of which—

(1) not less than $110,000,000 shall be made available each such fiscal year for activities under paragraphs (1) and (4) of subsection (a);

(2) not less than $60,000,000 shall be made available each such fiscal year for activities under subsection (a)(3); and

(3) not less than $32,000,000 shall be made available each such fiscal year for activities under subsection (a)(2).

SEC. 3305. ADVANCING RESEARCH AND TREATMENT FOR PAIN CARE MANAGEMENT.

(a) Institute of Medicine Conference on Pain.

(1) Convening.—Not later than 1 year after funds are appropriated to carry out this subsection, the Secretary of Health and Human Services shall seek to enter into an agreement with the Institute of Medicine of the National Academies to convene a Conference on Pain (in this subsection referred to as ‘‘the Conference’’).

(2) Purpose.—The purposes of the Conference shall be to—

(A) increase the recognition of pain as a significant public health problem in the United States;

(B) evaluate the adequacy of assessment, diagnosis, treatment, and management of acute and chronic pain in the general population, including ethnic, gender, age, and other demographic groups that may be disproportionately affected by inadequacies in the assessment, diagnosis, treatment, and management of pain;

(C) identify barriers to appropriate pain care;

(D) establish an agenda for action in both the public and private sectors that will reduce such barriers and significantly improve the state of pain care research, education, and clinical care in the United States;

(E) make recommendations on how to expand partnerships between public entities and private entities to expand collaborative, cross-cutting research.

(b) Report.—A report summarizing the Conference’s findings and recommendations shall be submitted to the Congress not later than June 30, 2011.

(c) Authorization of Appropriations.—For purposes of paragraph (2), there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 and 2011.

(d) Pain Research at National Institutes of Health. —Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.) is amended by adding at the end the following:

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SEC. 406. PAIN RESEARCH INITIATIVES.

(1) IN GENERAL.—The Director of NIH is authorized to award grants, contracts, and cooperative agreements to conduct research and clinical trials of high scientific merit and potential to improve the quality of life of people with pain.

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2017 for activities under paragraph (1) totaling $190,000,000.

(3) REPORT.—Not more than 2 years after the award of grants, contracts, and cooperative agreements under paragraph (1), the Secretary shall submit an evaluation of the results of projects awarded under paragraph (1) to the Congress and the Institute of Medicine.

(4) RESEARCH INITIATIVES.—

(a) IN GENERAL.—Subject to the availability of appropriations, the Secretary of Health and Human Services shall establish an agenda for action in both the public and private sectors that will reduce barriers to innovative research on pain care and significantly improve the state of pain care research, education, and clinical care in the United States.

(b) CERTAIN TOPICS.—An award may be made only if the Secretary determines that the proposed activities are focused on one or more of the following topics:

(1) research on the biology, diagnosis, treatment, and management of pain;

(2) research on the causes, nature, and treatment of pain-related conditions;

(3) research on the behavioral, economic, ethical, and legal implications of pain;

(4) research on the interaction of pain with other chronic conditions and treatments;

(5) research on pain in children and the elderly; and

(6) research on mechanisms that prevent unnecessary duplication of effort.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2017 for activities under paragraph (1) totaling $190,000,000.

(6) REPORT.—Not later than 2 years after the award of grants, contracts, and cooperative agreements under paragraph (1), the Secretary shall submit an evaluation of the results of projects awarded under paragraph (1) to the Congress and the Institute of Medicine.

(7) RULES.—In carrying out the provisions of this section, the Secretary shall—

(A) consult with nationally recognized pain experts; and

(B) ensure that the results of research and demonstration projects are disseminated to health professionals and pain patients in a timely and efficient manner.

(8) DEFINITIONS.—In this subsection—

(1) the term ‘‘Pain Consortium’’ means the Pain Consortium of the National Institutes of Health; and

(2) the term ‘‘Institute of Medicine’’ means the Institute of Medicine of the National Academies.

SEC. 759. PROGRAM FOR EDUCATION AND TRAINING IN PAIN CARE.

(a) Program.—The Secretary may make awards of grants, contracts, and cooperative agreements to conduct pain care research and training to health care professionals in pain care.

(b) Certain Topics.—An award may be made under subsection (a) only if the application for the award carries out with the award will include information and education on..."
"(1) recognized means for assessing, diag-
nosing, treating, and managing pain and re-
lated signs and symptoms, including the medically appropriate use of controlled substances;

"(2) applicable laws, regulations, rules, and
policies on controlled substances, including
the degree to which misconceptions and con-
cerns about such laws, regulations, rules, and
policies, or the enforcement thereof, may
create barriers to patient access to ap-
propriate and effective pain care;

"(3) interdisciplinary approaches to the de-
delivery of pain care, including delivery
through specialized centers providing com-
prehensive pain care treatment expertise;

"(4) systemic, diagnostic, geographic, and
other barriers to care in under-
served populations; and

"(5) recent findings, developments, and im-
provements in pain care.

"(c) EVALUATION OF PROGRAMS.—The Sec-
reaty shall (directly or through grants or
contracts) provide for the evaluation of pro-
grams implemented under subsection (a) in
order to determine the effect of such pro-
grams on knowledge and practice of pain care.

"(d) PAIN CARE DEFINED.—For purposes of this
section the term ‘pain care’ means the as-
sessment, diagnosis, treatment, or man-
gagement of the pain regardless of causation
or body location.

"(e) AUTHORIZATION OF APPROPRIATIONS.—
There is appropriated to carry out this section, such sums as may be
necessary for each of the fiscal years 2010
through 2012. Amounts appropriated under
this subsection shall remain available until
expended.”.

SEC. 3306. FUNDING FOR CHILDHOOD OBESITY
DEMONSTRATION PROJECTS.
Section 751(a)(8) of the Social Security Act (42 U.S.C. 1320b-9a(e)(8)) is amended to read as follows:

“(B) APPROPRIATION.—Out of any funds in the terms ‘health care career pathway’ means a
rigorous, engaging, and high quality set of
courses and services that—

(A) includes an articulated sequence of academic and career courses, including 21st
century skills.

(B) is aligned with the needs of healthcare
industries in a region or State;

(C) prepares students into the full
range of postsecondary education options,
including registered apprenticeships, and
careers;

(D) provides academic and career coun-
seling in student-to-counselor ratios that
allow students to make informed decisions
about academic and career options;

(E) meets State academic standards, State
requirements for secondary school gradua-
tion and is aligned with requirements for
entry into postsecondary education, and ap-
plies industry standards; and

(F) leads to 2 or more credentials, includ-
ing—

(i) a secondary school diploma; and

(ii) a postsecondary degree, an appren-
ticeship or other occupational certification,
a certificate, or a license.

(3) INSTITUTION OF HIGHER EDUCATION.—The
term ‘institution of higher education’ has the
meaning given the term in sections 101 and
102 of the Higher Education Act of 1965
(20 U.S.C. 1001 and 1002).

(4) LOCAL WORKFORCE INVESTMENT BOARD;
LOCAL WORKFORCE INVESTMENT BOARD.

"(A) LOW-INCOME INDIVIDUAL.—The term
‘low-income individual’ means an individ-
ual that is given that term in section 101 of the Work-

"(B) STATE WORKFORCE INVESTMENT BOARD;
LOCAL WORKFORCE INVESTMENT BOARD.—The
terms ‘State workforce investment board’ and
‘local workforce investment board’;

"(C) HIGH-LEVERAGE INVESTMENT PROGRAM;

"(D) LEADERSHIP AND INNOVATION, LOCAL
WORKFORCE INVESTMENT BOARD, AND LOCAL
WORKFORCE INVESTMENT BOARD.

"(A) LOW-INCOME INDIVIDUAL.—The term
‘low-income individual’ means an individ-
ual that is given that term in section 101 of the Work-
principal functions identifying and implementing strategies and activities that address health care workforce needs in its service area, in coordination with the local workforce investment board.

(14) CLINICAL SOCIAL WORKER.—The term ‘clinical social worker’ has the meaning given the term in section 1861(h)(1) of the Social Security Act (42 U.S.C. 1395x(h)(1)).

(15) CULTURAL COMPETENCY.—The term ‘cultural competency’ shall be defined by the Secretary in a manner consistent with section 327 of the Older Americans Act of 1965 (42 U.S.C. 3027).

(16) DIRECT CARE WORKER.—The term ‘direct care worker’ has the meaning given that term in the 2010 Standard Occupational Classification system of the Bureau of Labor Statistics (BLS).

(17) FEDERALLY QUALIFIED HEALTH CENTER.—The term ‘Federally qualified health center’ has the meaning given that term in section 1861(aa) of the Social Security Act (42 U.S.C. 1395aa).

(18) FRONTIER HEALTH PROFESSIONAL SHORTAGE AREA.—The term ‘frontier health professional shortage area’ means an area—

(A) with a population density less than 6 persons per square mile within the service area; and

(B) with respect to which the distance or time for the population to access care is excessive.

(19) GRADUATE PSYCHOLOGY.—The term ‘graduate psychology’ means an accredited program in professional psychology.

(20) HEALTH DISPARITY POPULATION.—The term ‘health disparity population’ has the meaning given such term in section 993(d)(1).

(21) HEALTH LITERACY.—The term ‘health literacy’ means the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health decisions.

(22) MENTAL HEALTH SERVICE PROFESSIONAL.—The term ‘mental health service professional’ means an individual with a graduate or postgraduate degree from an accredited institution of higher education in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, and related mental health care disciplines, who are directly involved in health professions education or practice.

(23) ONE-STOP DELIVERY SYSTEM CENTER.—The term ‘one-stop delivery system center’ has the meaning given in the Workforce Investment Act of 1998 (29 U.S.C. 2868(c)).

(24) PARAPROFESSIONAL CHILD AND ADOLESCENT MENTAL HEALTH WORKER.—The term ‘paraprofessional child and adolescent mental health worker’ means an individual who is not a mental or behavioral health service professional, but who works at the first stage of contact with children and families who are directly involved in mental health services, including substance abuse prevention and treatment services.

(25) RACIAL AND ETHNIC MINORITY GROUP; RACIAL AND ETHNIC MINORITY POPULATION.—The terms ‘racial and ethnic minority group’ and ‘racial and ethnic minority population’ have the meaning given the term ‘racial and ethnic minority population’ in section 503 of this Act.

(26) RURAL HEALTH CLINIC.—The term ‘rural health clinic’ has the meaning given that term in section 1861(aa) of the Social Security Act (42 U.S.C. 1395aa).

(c) TITLE VIII OF THE PUBLIC HEALTH SERVICE ACT.—Section 801 of the Public Health Service Act (42 U.S.C. 296) is amended—

(1) in paragraph (2)—

(A) by striking ‘means a’ and inserting ‘means an accredited (as defined in paragraph 6)’; and

(B) by striking the period at the end of clause (i) and inserting a period at the end of clause (ii)

(2) in subsection (b)(1)—

(VIII) educational institutions (which may include elementary and secondary institutions, institutions of higher education, including 2 and 4 year institutions, or registered apprenticeship programs).

(II) ADDITIONAL MEMBERS.—The remaining membership may include additional representatives from clause (i) and other individuals as determined appropriate by the Comptroller General of the United States.

(c) TITLE VIII OF THE PUBLIC HEALTH SERVICE ACT.—Section 801 of the Public Health Service Act (42 U.S.C. 296) is amended—

(1) in paragraph (2)—

(A) by striking ‘means a’ and inserting ‘means an accredited (as defined in paragraph 6)’; and

(B) by striking the period following the word “professional” and inserting a period at the end of the paragraph

(2) in subsection (b)(1)—

(VIII) educational institutions (which may include elementary and secondary institutions, institutions of higher education, including 2 and 4 year institutions, or registered apprenticeship programs).

(II) ADDITIONAL MEMBERS.—The remaining membership may include additional representatives from clause (i) and other individuals as determined appropriate by the Comptroller General of the United States.

Subtitle B—Innovations in the Health Care Workforce

SEC. 4101. NATIONAL HEALTH CARE WORKFORCE COMMISSION.

(a) PURPOSE.—It is the purpose of this section to establish a National Health Care Workforce Commission that—

(1) serves as a national resource for Congress, the President, States, and localities;

(2) establishes criteria for the filling of positions in health care worker shortages;

(3) develops and commissions evaluations of education and training activities to determine whether the demand for health care workers is being met;

(4) identifies barriers to improved coordination at the Federal, State, and local levels and recommend ways to address such barriers;

(5) encourages innovations to address population needs, constant changes in technology, and other environmental factors.

(b) ESTABLISHMENT.—There is hereby established the National Health Care Workforce Commission (in this section referred to as the ‘Commission’).

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members to be appointed by the Comptroller General, without regard to section 5 of the Federal Advisory Committee Act (5 U.S.C. App.).

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of the Commission shall include individuals—

(i) with expertise in health care workforce analysis, including health care workforce analysis, health care finance and economics; health care system transformation; health care quality measurement; integrated delivery systems; health care workforce education and training; health care philanthropy; providers of health care services; and other health care stakeholders;

(ii) who will provide a combination of professional perspectives, broad geographic representation, and a balance between urban, suburban, rural, and frontier representatives.

(B) INCLUSION.—

(i) IN GENERAL.—The membership of the Commission shall include no less than one representative of—

(I) the health care workforce and health professional organizations;

(II) employers;

(III) third-party payers;

(IV) individuals skilled in the conduct and interpretation of workforce services and health economics research;

(V) representatives of consumers;

(VI) labor unions;

(VII) State or local government investment boards; and

(VIII) educational institutions which may include elementary and secondary institutions, institutions of higher education, including 2 and 4 year institutions, or registered apprenticeship programs.

(ii) ADDITIONAL MEMBERS.—The remaining membership may include additional representatives from clause (i) and other individuals as determined appropriate by the Comptroller General of the United States.
the Government Accountability Office for any purpose.
(5) CHAIRMAN, VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the chairmanship or vice chairmanship, the Comptroller General may designate another member for the remainder of that member’s term.
(6) MEETINGS.—The Commission shall meet at the call of the chairman, but no less frequently than on a quarterly basis.

(1) RECOGNITION, DISSEMINATION, AND COMMUNICATION.—The Commission shall—
(A) recognize efforts of Federal, State, and local agencies, Indian tribes, voluntary health care organizations, professional societies, and other relevant public-private health care partnerships.
(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;
(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));
(D) prescribe such rules and regulations as the Commission determines to be necessary with respect to the organization and operation of the Commission.

(g) POWERS.—
(1) DATA COLLECTION.—In order to carry out its functions under this section, the Commission shall—
(A) utilize existing information, both published and unpublished, where possible, collected and observed by its own staff or under other arrangements made in accordance with this section, including coordination with the Bureau of Labor Statistics;
(B) carry out, or award grants or contracts for carrying out, such studies and research as it may determine to be necessary, and for recruiting and training for careers in health care, including public health and allied health;
(C) adopt procedures allowing interested parties to submit information for the Commission’s use in making reports and recommendations.

(4) STUDY.—The Commission shall study the effect of Federal policies and practices that affect the health care workforce, including public health and allied health.

(5) REPORT.—The Commission shall submit a report to Congress on or before October 1 of each year concerning related policies; and the results of such reviews and recommendations concerning national health care workforce priorities, goals, and policies;
(B) by not later than April 1 of each year (beginning with 2011), submit a report to Congress and the Administration concerning national health care workforce supply and demand, including the topics described in paragraph (3);
(C) by not later than October 1 of each year (beginning with 2011), submit a report to the Comptroller General to develop another health care career pathways of proven effectiveness;
(D) by not later than April 1 of each year (beginning with 2011), submit a report to the Comptroller General concerning the topics described in paragraph (3);
(E) the health care workforce needs of special populations, such as minorities, rural populations, underserved communities, and the elderly;
(F) recommendations creating or revising national health care workforce educational and scholarship programs to require low-income, minority medical students to serve in their home communities, if designated as medical underserved community.

(4) HIGH PRIORITY AREAS.—
(A) IN GENERAL.—The initial high priority topics described in this paragraph include each of the following:
(i) Integrated health care workforce planning that identifies health care professional skills needed and maximizes the skill sets of health care providers and disciplines.
(ii) An analysis of the nature, scopes of practice, and demands for health care workers in the enhanced information technology and management workforce.
(iii) The education and training capacity, projected demands, and integration with the health care delivery system of each of the following:
(I) Nursing workforce capacity at all levels.
(II) Oral health care workforce capacity at all levels.
(III) Mental and behavioral health care workforce capacity at all levels.
(IV) Allied health and public health care workforce capacity at all levels.
(V) Emergency medical service workforce capacity, including the retention and recruitment of the volunteer workforce, at all levels.
(VI) The geographic distribution of health care providers as compared to the identified health care workforce needs of States and regions.
(B) FUTURE DETERMINATIONS.—The Commission may require that additional topics be included under subparagraph (A). The appropriate committees of Congress may recommend to the Commission the inclusion of additional workforce development areas that require special attention.

(5) GRANT PROGRAM.—The Commission shall—
(A) review implementation progress reports on, and report to Congress about, the State Health Care Workforce Development Grant program established in section 4102;
(B) in collaboration with the Department of Labor and in coordination with the Department of Education and other relevant Federal agencies, make recommendations to the President and Congress under section 4102(b) for grant recipients under section 4102;
(C) assess the implementation of the grants under such section; and
(D) collect performance and report information, including identified models and best practices, on grants from the fiscal and administrative agent under such section and distribute this information to Congress, relevant Federal agencies, and to the public.

(6) STUDY.—The Commission shall study the effect of Federal policies and practices that affect the health care workforce, including public health and allied health.

(7) RECOMMENDATIONS.—The Commission shall report to Congress, the Department of Labor, and the Department of Health and Human Services about improving safety, health, and worker protections in the workplace for the health care workforce.

(8) ASSESSMENT.—The Commission shall assess and receive reports from the National Center for Health Workforce Analysis established under section 761(b) of the Public Health Service Act (as amended by section 4102), and such other reports as the Commission deems necessary to carry out its functions in this section.
teaching hospitals, and ambulatory health professionals, physical and occupational therapists (as so defined), social workers, pharmacists, chiropractors, allied health, education agency, the State P–16 or P–20 education, a public 4-year institution of higher education, the recognized State education agency, the State P–16 or P–20 education, a public 2-year institution of higher education, a public 2-year institution of higher education, the Administration at such time and in such manner, as the Administration determines appropriate.

(2) Health professionals.—The term "health professionals" includes all health care providers with direct patient care and support responsibilities, such as physicians, nurses, dental hygienists, other oral health care professionals, preventive medicine physicians, optometrists, ophthalmologists, physician assistants, pharmacists, dentists, mental health professionals, allied health professionals, doctors of chiropractic, community health workers, health care paraprofessionals, direct care workers, nurses, and mental and behavioral health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, certified nurse midwives, nurse practitioners, physician assistants, mental health professionals, and any other health care providers.

(3) Public or private sector.—The term "public or private sector" includes—

(A) health professions; and

(B) national representatives of health professions;

(C) representatives of schools of medicine, osteopathy, nursing, dentistry, optometry, pharmacy, chiropractic, allied health, educational programs for public health professionals, mental health professionals (as so defined), social workers, pharmacists, physical and occupational therapists, oral health care industry dentistry and dental hygiene, and other health care services;

(D) representatives of public and private teaching hospitals, and ambulatory health facilities, including Federal medical facilities; and

(E) any other health professional the Comptroller General of the United States determines appropriate.

SEC. 4102. STATE HEALTH CARE WORKFORCE DEVELOPMENT GRANTS.

(a) Establishment.—There is established a competitive health care workforce development grant program (in this section as the "program") for the purpose of enabling State partnerships to complete comprehensive planning and to carry out activities leading to an integrated health care workforce development strategies at the State and local levels.

(b) Program and Administrative Agent.—The Health Resources and Services Administration of the Department of Health and Human Services (referred to in this section as the "Administration") shall be the fiscal and administrative agent for the grants awarded under this section. The Administration is authorized to carry out the program, in consultation with the National Health Care Workforce Commission (referred to in this section as the "Commission"), which shall review reports on the development, implementation, and progress of the activities of the grant program, including—

(1) administering the grants;

(2) providing technical assistance to grantees; and

(3) reporting performance information to the Commission.

(c) Planning Grants.—

(1) Amount and Duration.—A planning grant shall be awarded under this subsection for a period of not more than one year and the maximum award may not be more than $150,000.

(2) Eligibility.—To be eligible to receive a planning grant, an entity shall be an eligible partnership. An eligible partnership shall be a State partnership receiving a planning grant. The matching requirement may be provided from funds available under other Federal, State, local or private sources to carry out the activities.

(3) Report to Administration.—

(A) Each State partnership shall submit a report to the Administration on the State’s performance of the activities under the grant, including the use of funds, including matching funds, to carry out required activities, and a description of the progress of the State workforce investment board in meeting the performance benchmarks.

(B) Report to Congress.—

The Administration shall submit a report to Congress analyzing the planning activities, performance, and fund utilization of each State grant recipient, including an identification of promising practices and a profile of the activities of each State grant recipient.

(d) Implementation Grants.—

(1) In General.—The Administration shall—

(A) competitively award implementation grants to State partnerships to enable such partnerships to implement activities that will result in a coherent and comprehensive plan for health workforce development that will respond to current and projected workforce demands within the State; and

(B) inform the Commission and Congress about the awards made.

(2) Duration.—An implementation grant shall be awarded for a period of no more than 2 years, except in those cases where the Administration determines that the grantee is high performing and the activities supported by the grant warrant up to 1 additional year of funding.

(3) Eligibility.—To be eligible for an implementation grant, a State partnership shall have—

(A) received a planning grant under subsection (c) and completed all requirements of subpart (1); or

(B) completed a satisfactory application, including a plan to coordinate with required
partners and complete the required activities during the 2-year period of the implementation grant.

4. Fiscal and Administrative Agent.—A State partnership receiving an implementation grant shall appoint a fiscal and an administrative agent for the administration of such grant.

5. Application.—Each eligible State partnership describing an implementation grant shall submit an application to the Administration at such time, in such manner, and accompanied by such information as the Administration reasonably requires. Each application submitted shall include—

A. a description of the members of the State partnership;
B. a description of how the State partnership completed the required activities under the planning grant, if applicable;
C. a description of the activities for which implementation grants may be used to support collaboration and capacity building activities;
D. a description of how the State partnership will coordinate with required partners and complete the required partnership activities during the duration of an implementation grant;
E. a description of the cost of the activities supported by the implementation grant and a timeline for the provision of matching funds;
F. proposed performance benchmarks to be used to assess and evaluate the progress of the partnership activities;
G. a description of how the State partnership will collect data to report progress in grant activities; and
H. such additional assurances as the Administration may deem essential to ensure compliance with grant requirements.

6. Required Activities.—

A. In General.—A State partnership that receives an implementation grant may receive not less than 60 percent of the grant funds to make grants to be competitively awarded by the State partnership, consistent with requirements under State procurement rules, to encourage regional partnerships to advance coherent and comprehensive regional health care workforce planning activities, in coordination to the extent practicable with State or local policies to reduce Federal, State, or local barriers to health care workforce; the alignment of curricula for health care workforce planning, including the potential use of performance measures and benchmarks for programs under title II; and the Administration or the Secretary as the ‘National Center’.

B. Eligible Partnership Duties.—An eligible State partnership receiving an implementation grant shall—

1. identify and convene regional leadership to discuss opportunities to engage in statewide health care workforce development planning, including the potential use of performance measures and benchmarks for programs under title II; and
2. (b) Reporting.—The Administration shall submit a report to Congress analyzing implementation activities under subsection (d), including the use of performance measures and benchmarks for programs under this section.

7. Performance Evaluation.—Before the State partnership receives an implementation grant, it and the Administration jointly shall determine the performance benchmarks that shall be established for the purposes of the implementation grant.

8. Match.—Each State partnership receiving an implementation grant shall provide an amount, in cash or in kind that is not less than 25 percent of the amount of the grant, to carry out the activities supported by the grant. The matching funds may be provided from funds available from other Federal, State, local, or private sources to carry out such activities.

9. Reports.—

A. Report to Administration.—For each year of the implementation grant, the State partnership receiving the implementation grant shall submit a report to the Administration on the performance of the State grant activities, including a description of the use of performance measures and benchmarks for programs under this section.

B. Report to Congress.—The Administration shall submit a report to Congress analyzing implementation activities under subsection (d), including the use of performance measures and benchmarks for programs under this section.

C. Authorization for Appropriations.—

1. Planning Grants.—There are authorized to be appropriated to award planning grants under subsection (c) $150,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

2. Implementation Grants.—There are authorized to be appropriated to award implementation grants under subsection (d), $150,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

SEC. 4102. HEALTH CARE WORKFORCE ASSESSMENT.

(a) In General.—Section 761 of the Public Health Service Act (42 U.S.C. 294m) is amended—

(1) by redesignating subsection (c) as subsection (e); and
(2) by striking subsection (b) and inserting the following:

(b) National Center for Health Care Workforce Analysis.—

1. Establishment.—The Secretary shall establish the National Center for Health Workforce Analysis (referred to in this section as the ‘National Center’).

2. Purposes.—The National Center, in coordination to the extent practicable with the National Health Care Workforce Commission (established in section 4101 of the Patient Protection and Affordable Care Act), and relevant regional and State centers and agencies, shall—

(A) study and recommend measures for developing information describing and analyzing the health care workforce and workforce-related issues;
(B) carry out the activities under section 762(a)(4).

(c) Annual Evaluation.—The Secretary shall annually evaluate programs under this title; and

(d) Reporting.—The Secretary shall annually report on programs under this title.

(e) Authorization for Appropriations.—

1. Planning Grants.—There are authorized to be appropriated to award planning grants under subsection (c) $150,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

2. Implementation Grants.—There are authorized to be appropriated to award implementation grants under subsection (d), $150,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

SEC. 4103. HEALTH CARE WORKFORCE TRAINING.

(a) State and Regional Centers for Health Workforce Analysis.—

(1) In General.—The Secretary shall award grants to or enter into contracts with eligible entities for purposes of—

(A) collecting, analyzing, and reporting data regarding programs under this title to the National Center and to the public; and

(B) providing technical assistance to local and regional entities on the collection, analysis, and reporting of data.

(2) Eligible Entities.—To be eligible for a grant or contract under this subsection, an entity shall—

(A) be a State, a State workforce investment board, a public health or health professions school, an academic health center, or an appropriate public or private nonprofit entity; and

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(b) Contracts for Health Workforce Analysis.—For the purpose of carrying out the activities described in paragraph (a), the National Center may enter into contracts with relevant professional and educational organizations or societies.

(c) State and Regional Centers for Health Workforce Analysis.—

(1) In General.—The Secretary shall award grants to or enter into contracts with eligible entities for purposes of—

(A) collecting, analyzing, and reporting data regarding programs under this title to the National Center and to the public; and

(B) providing technical assistance to local and regional entities on the collection, analysis, and reporting of data.

(2) Eligible Entities.—To be eligible for a grant or contract under this subsection, an entity shall—

(A) be a State, a State workforce investment board, a public health or health professions school, an academic health center, or an appropriate public or private nonprofit entity; and

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(d) Increase in Grants for Longitudinal Evaluations.—

(1) In General.—The Secretary shall increase the amount awarded to an eligible entity under this title for a longitudinal evaluation of individual who have received education, training, or other financial assistance from programs under this title.

(2) Capability.—A longitudinal evaluation shall be capable of—

(A) studying practice patterns; and

(B) collecting and reporting data on performance measures developed under sections 749(d)(3), 757(d)(3), and 762(a)(3).

(e) Guidelines.—A longitudinal evaluation shall comply with guidelines issued under sections 749(d)(4), 757(d)(4), and 762(a)(4).
(b) TRANSFERS.—Not later than 180 days after the date of enactment of this Act, the responsibilities and resources of the National Center for Health Workforce Analysis, as in effect on the date before the date of enactment of this Act, shall be transferred to the National Center for Health Workforce Analysis as established under section 761 of the Public Health Service Act, as amended by subsection (a).

(c) USE OF LONGITUDINAL EVALUATIONS.—Section 761(d)(2) of the Public Health Service Act (42 U.S.C. 297(b)(2)) is amended—

(1) in subparagraph (A), by striking “or” at the end;

(2) in subparagraph (B), by striking the period and inserting “; or”;

and

(3) by adding at the end the following:

“(C) utilizes a longitudinal evaluation (as described in section 761(d)(2)) for programs under this part; and

(d) PERFORMANCE MEASURES; GUIDELINES FOR LONGITUDINAL EVALUATIONS.—

(1) ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY.—Section 746(d) of the Public Health Service Act is amended—

(A) in paragraph (1), by striking “and” at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

“(3) develop, publish, and implement performance measures for programs under this part;

“(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

“(5) recommend appropriation levels for programs under this part.

(2) ADVISORY COMMITTEE ON INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES.—Section 756(d) of the Public Health Service Act is amended—

(A) in paragraph (1), by striking “and” at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

“(3) develop, publish, and implement performance measures for programs under this part; and

“(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

“(5) recommend appropriation levels for programs under this part.

(3) ADVISORY COUNCIL ON GRADUATE MEDICAL EDUCATION.—Section 762(a) of the Public Health Service Act (42 U.S.C. 297b(a)) is amended—

(A) in paragraph (1), by striking “and” at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

“(3) develop, publish, and implement performance measures for programs under this part; and

“(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

“(5) recommend appropriation levels for programs under this part.

(4) ADVISORY COUNCIL ON USE OF LONGITUDINAL EVALUATIONS.—Section 761(d) of the Public Health Service Act (42 U.S.C. 297(b)) is amended—

(A) in paragraph (1), by striking “and” at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

“(3) develop, publish, and implement performance measures for programs under this part; and

“(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

“(5) recommend appropriation levels for programs under this part.

(5) ADVISORY COMMITTEE ON LONGITUDINAL EVALUATIONS.—Section 791(a) of the Public Health Service Act (42 U.S.C. 297b(a)) is amended—

(A) in paragraph (1), by striking “and” at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

“(3) develop, publish, and implement performance measures for programs under this part; and

“(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

“(5) recommend appropriation levels for programs under this part.

(6) ADVISORY COUNCIL ON STABILITY OF HEALTH PROFESSIONAL SUPPLY.—Section 2 of the Health Resources and Services Administration in accordance with the preceding sentence.

SEC. 4202. NURSING STUDENT LOAN PROGRAM.

(a) LOAN AGREEMENTS.—Section 836(a) of the Public Health Service Act (42 U.S.C. 297a) is amended—

(1) by striking “$2,500” and inserting “$3,300”;

(2) by striking “$4,000” and inserting “$5,000”;

and

(3) by striking “$13,000” and all that follows through the period and inserting “to be adjusted to provide for a cost-of-living increase for the yearly loan rate and the aggregate of the loans.”;

(b) LOAN PROVISIONS.—Section 836(b) of the Public Health Service Act (42 U.S.C. 297a(b)) is amended—

(1) by striking “$2,500” and inserting “$3,300”;

(2) by striking “$4,000” and inserting “$5,000”;

and

(3) by striking “$13,000” and all that follows through the period and inserting “to be adjusted to provide for a cost-of-living increase for the yearly loan rate and the aggregate of the loans.”;

(c) USE OF LONGITUDINAL EVALUATIONS.—Section 102 of the Public Health Service Act (42 U.S.C. 294n-1) is amended—

(A) in paragraph (1), by striking “and” at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon;

and

(C) by adding at the end the following:

“(3) develop, publish, and implement performance measures for programs under this part; and

“(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

“(5) recommend appropriation levels for programs under this part.

(4) ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY.—Section 746(d) of the Public Health Service Act (42 U.S.C. 297b(a)) is amended—

(A) in paragraph (1), by striking “and” at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

“(3) develop, publish, and implement performance measures for programs under this part; and

“(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

“(5) recommend appropriation levels for programs under this part.

(5) ADVISORY COMMITTEE ON USE OF LONGITUDINAL EVALUATIONS.—Section 761(d) of the Public Health Service Act (42 U.S.C. 297(b)) is amended—

(A) in paragraph (1), by striking “and” at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

“(3) develop, publish, and implement performance measures for programs under this part; and

“(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

“(5) recommend appropriation levels for programs under this part.

(6) ADVISORY COUNCIL ON STABILITY OF HEALTH PROFESSIONAL SUPPLY.—Section 2 of the Health Resources and Services Administration in accordance with the preceding sentence.

SEC. 4203. HEALTH CARE WORKFORCE LOAN REPAYMENT PROGRAMS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

“Subpart C—Repayment and Retention Programs

SEC. 775. INVESTMENT IN TOMORROW’S PEDIATRIC HEALTH CARE WORKFORCE.

(a) ESTABLISHMENT.—The Secretary shall establish and carry out a pediatric specialty loan repayment program under which the eligible individual agrees to be employed full-time for a specified period (which shall not be less than 2 years) in providing pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including subspecialty prevention and treatment services.

(b) PROGRAM ADMINISTRATION.—Through the program established under this section, the Secretary shall enter into contracts with qualified health professionals under which—

(1) such qualified health professionals will agree to provide pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care in an area with a shortage of the specified pediatric subspecialty that has a sufficient pediatric population to support such pediatric subspecialty, as determined by the Secretary; and

(2) the Secretary agrees to make payments on the principal and interest of undergraduate, graduate, or graduate medical education loans of professionals described in paragraph (1) of not more than $35,000 a year for each year of agreed upon service under such program for a period of not more than 3 years during the qualified health professional’s career.

(A) participation in an accredited pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care subspecialty residency or fellowship; or

(B) employment as a pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care subspecialty residency or fellowship serving an area or population described in such paragraph.

(2) ELIGIBLE INDIVIDUALS.—

(A) PEDIATRIC MEDICAL SPECIALISTS AND PEDIATRIC SURGICAL SPECIALISTS.—For purposes of contracts with respect to pediatric medical subspecialty and pediatric surgical specialists, the term ‘qualified health professional’ means a licensed physician who—

(i) is entering or receiving training in an accredited pediatric medical subspecialty or pediatric surgical specialty residencies or fellowships;

(ii) has completed (but not prior to the end of the calendar year in which this section is enacted) the training described in subparagraph (B).

(B) CHILD AND ADOLESCENT MENTAL AND BEHAVIORAL HEALTH.—For purposes of contracts with respect to child and adolescent mental and behavioral health care, the term ‘qualified health professional’ means a licensed professional who—

(i) has received specialized training or clinical experience in child and adolescent mental and behavioral health care in specialty training, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family therapy, school counseling, or professional counseling;

(ii) has a license or certification in a State to practice allographic medicine, osteopathic medicine, professional counseling, psychology, psychiatric nursing, social work, school social work, marriage and family therapy, school counseling, or professional counseling; or

(iii) is a mental health service professional who completed (but not prior to the end of the calendar year in which this section is enacted) specialized training or clinical experience in child and adolescent mental health described in clause (i).

(3) ADDITIONAL ELIGIBILITY REQUIREMENTS.—The Secretary may not enter into a contract under this subsection with an eligible individual unless—

(A) the individual agrees to work in, or for a provider serving, a health professional shortage area or medically underserved area, or to serve a medically underserved population;

(B) the individual is a United States citizen or a permanent legal United States resident; and

(C) the individual is enrolled in a graduate medical education program, the program is accredited, and the individual has an acceptable level of academic standing (as determined by the Secretary).

(4) PRIORITY.—In entering into contracts under this subsection, the Secretary shall give priority to applicants who—
“(1) are or will be working in a school or other pre-kindergarten, elementary, or secondary education setting;

“(2) have familiarity with evidence-based methods and linguistic competence in health care services; and

“(3) demonstrate financial need.

“SEC. 4204. PUBLIC HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 4203, is further amended by adding at the end the following:

“SEC. 776. PUBLIC HEALTH WORKFORCE LOAN REPAYMENT PROGRAM.

“(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Loan Repayment Program (referred to in this section as the ‘Program’) to ensure an adequate supply of public health professionals to eliminate critical public health workforce shortages in rural, state, local, and tribal public health agencies.

“(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

“(1) for enrollment, or be enrolled, as a student in an accredited academic educational institution in a State or territory in the final year of a course of study or program leading to a public health or health professions degree or certificate; and

“(2) be a United States citizen; and

“(3)(A) submit an application to the Secretary;

“(B) execute a written contract as required in subsection (c); and

“(C) have received, for the same service, a reduction of loan obligations under section 455(m), 428J, 428K, 428L, or 460 of the Higher Education Act of 1965.

“(c) CONTRACT.—The written contract (referred to in this section as the ‘written contract’) between the Secretary and an individual shall contain—

“(1) an agreement on the part of the Secretary that the Secretary will repay on behalf of the individual loans incurred by the individual in the pursuit of the relevant degree of education or training, in accordance with the terms of the contract;

“(2) an agreement on the part of the individual that the individual will serve in the full-time employment of a Federal, State, local, or tribal public health agency or a related fellowship program in a position related to the course of study or program for which the contract was awarded for a period of time (referred to in this section as the ‘period of obligated service’) equal to the greater of—

“(A) 3 years; or

“(B) such longer period of time as determined appropriate by the Secretary and the individual;

“(3) an agreement, as appropriate, on the part of the individual to relocate to a priority service area (as determined by the Secretary) in exchange for an additional loan repayment incentive amount to be determined by the Secretary;

“(4) a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual that is conditioned thereon, is contingent on funds being appropriated for loan repayments under this section;

“(5) a statement of the damages to which the United States is entitled, under this section, for the individual’s breach of the contract; and

“(6) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

“(d) PAYMENTS.—

“(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans made to the individual by a public health agency or a related institution, or by another Federal, State, tribal, or local public health agency, or related entity, or by the individual, incurred by the individual.

“(2) PAYMENTS TO BE MADE.—For each year of obligated service that an individual contracts to serve under subsection (c) the Secretary may pay up to $35,000 on behalf of the individual for loans described in paragraph (1) or for related expenses to an individual who has completed pursuant to the Program whose total eligible loans are less than $100,000, the Secretary shall pay an amount that does not exceed 1⁄3 of the eligible loan balance for each year of obligated service of the individual.

“(e) TAX LIABILITY.—For the purpose of providing reimbursement of tax liability resulting from payments under paragraph (2) on behalf of an individual, the Secretary shall, in addition to such payments, make payments to the individual in an amount not to exceed 39 percent of the total amount of loan repayments made for the taxable year involved.

“(f) POSTOBLIGATION SERVICED.—With respect to an individual receiving a degree or certificate from a health professions or related school, the date of the initiation of the period of obligated service may be postponed as approved by the Secretary.

“(g) BREAK OF CONTRACT.—An individual who fails to comply with a contract entered into under subsection (c) shall be subject to the same financial penalties as provided for under section 338E for breaches of loan repayment contracts under section 338B.

“(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $195,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.

“SEC. 4205. ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

“(a) PURPOSE.—The purpose of this section is to assure an adequate supply of allied health professionals to eliminate critical allied health workforce shortages in Federal, State, local, or tribal public health agencies, or in settings where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.

“(b) ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAM.—

“(1) GRANT PROGRAM.—The Secretary shall establish an Allied Health Workforce Recruitment and Retention Program, which shall be carried out, for the taxable year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2013, to carry out subsection (c).

“(2) AMOUNT.—There is authorized to be appropriated to the Secretary to carry out the purposes of the Allied Health Workforce Recruitment and Retention Program $30,000,000 for each of fiscal years 2010 through 2013.

“(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $60,000,000 for fiscal year 2010 and such sums as may be necessary for each of the fiscal years 2011 through 2013.
for each of fiscal years 2011 through 2015. Fifty percent of appropriated funds shall be allotted to public health mid-career professionals and 50 percent shall be allotted to allied health professionals, and 50 percent shall be allotted to public health mid-career professionals, and 50 percent shall be allotted to allied health professionals.

SEC. 4207. FUNDING FOR NATIONAL HEALTH SERVICE CORPS.

Section 338a(a) of the Public Health Service Act (42 U.S.C. 254q(a)) is amended to read as follows:

“(a) AUTHORIZATION OF APPROPRIATIONS.—

For the purpose of carrying out this section, there is authorized to be appropriated, out of any funds in the Treasury not otherwise appropriated, the following:

”(1) For fiscal year 2010, $320,461,632.

”(2) For fiscal year 2011, $414,095,394.

”(3) For fiscal year 2012, $535,087,442.

”(4) For fiscal year 2013, $691,431,432.

”(5) For fiscal year 2014, $805,456,333.

”(6) For fiscal year 2015, $1,134,610,336.

”(7) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

”(A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and

”(B) one plus the average percentage change in the number of individuals residing in health professions shortage areas designated under section 333 during the prior fiscal year; or the number of individuals residing in such areas during the previous fiscal year.”.

SEC. 4208. NURSE-MANAGED HEALTH CLINICS.

(a) PURPOSE.—The purpose of this section is to fund the development and operation of nurse-managed health clinics.

(b) GRANTS.—Subpart 1 of part D of title III of the Public Health Service Act (42 U.S.C. 254q et seq.) is amended by inserting after section 330A the following:

“SEC. 330A–1. GRANTS TO NURSE-MANAGED HEALTH CLINICS.

“(a) DEFINITIONS.—

”(1) COMPREHENSIVE PRIMARY HEALTH CARE SERVICES.—In this section, the term ‘comprehensive primary health care services’ means the primary health services described in section 330(b)(1).

”(2) NURSE-MANAGED HEALTH CLINIC.—The term ‘nurse-managed health clinic’ means a nurse-practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health center.

”(b) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants for the cost of the operation of nurse-managed health clinics that meet the requirements of this section.

(c) APPLICATIONS.—To be eligible to receive a grant under this section, an entity shall—

”(1) be an NHMC; and

”(2) submit to the Secretary an application at such time, in such manner, and containing—

”(A) assurances that nurses are the major providers of services at the NHMC and that at least 1 advanced practice nurse holds an executive management position within the organizational structure of the NHMC.

”(B) an assurance that the NHMC will continue providing comprehensive primary health care services or wellness services without regard to income or insurance status of the patient for the duration of the grant period; and

”(C) evidence that, not later than 90 days of receiving a grant under this section, the NHMC will establish a community advisory committee, for which a majority of the members shall be individuals who are served by the NHMC.

”(d) GRANT AMOUNT.—The amount of any grant made under this section for any fiscal year shall be determined by the Secretary, taking into account—

”(1) the financial need of the NHMC, considering such other factors as the Secretary determines appropriate.

”(e) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this section, there are authorized to be appropriated $50,000,000 for the fiscal year 2010 and such sums as may be necessary for each of the fiscal years 2011 through 2014.”.

SEC. 4209. ELIMINATION OF CAP ON COMMISSIONED CORPS.

Section 302 of the Department of Health and Human Services Appropriations Act, 1993 (Public Law 102–294) is amended by striking “not to exceed 2,800”.

SEC. 4210. ESTABLISHING A READY RESERVE CORPS.

Section 203 of the Public Health Service Act (42 U.S.C. 204) is amended to read as follows:

“SEC. 203. COMMISSIONED CORPS AND READY RESERVE CORPS.

“(a) ESTABLISHMENT.—

”(1) IN GENERAL.—There shall be in the Service a commissioned Regular Corps and a Ready Reserve Corps for service in time of national emergency.

”(2) REQUIREMENT.—All commissioned officers shall be citizens of the United States and shall be appointed without regard to the classification the Classification Act of 1920, as amended.

”(3) APPOINTMENT.—Commissioned officers of the Ready Reserve Corps shall be appointed by the President with the advice and consent of the Senate.

”(4) ACTIVE DUTY.—Commissioned officers of the Ready Reserve Corps shall at all times be subject to call to active duty by the Surgeon General, including active duty for the purpose of providing support to the health care system sustained by the Service or any component thereof.

”(5) WARRANT OFFICERS.—Warrant officers may be appointed to the Service for the purpose of providing support to the health care system sustained by the Service or any component thereof

SEC. 4301. TRAINING IN FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS, AND PHYSICIAN ASSISTANTS.

Part C of title VII (42 U.S.C. 293k et seq.) is amended by striking section 747 and inserting the following:

“SEC. 747. PRIMARY CARE TRAINING AND ENHANCEMENT.

“(a) SUPPORT AND DEVELOPMENT OF PRIMARY CARE TRAINING PROGRAMS.—

”(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, an accredited public or nonprofit private hospital, school of medicine or osteopathic medicine, academically affiliated physician assistant training program, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant or contract—

”(A) to plan, develop, operate, or participate in an accredited primary care training program, including an accredited residency or internship program, for medical students, interns, residents, or practicing physicians as defined by the Secretary;

”(B) to provide need-based financial assistance in the form of fellowships and training opportunities to medical students, interns, residents, practicing physicians, or other medical personnel, who are participants in any such programs and who plan to specialize or work in the practice of the fields defined in subparagraph (A);

”(C) to plan, develop, and operate a program for the training of physicians teaching in family medicine, general internal medicine, or general pediatrics training programs;

”(D) to plan, develop, and operate a program for the training of physicians teaching in community-based settings;

”(E) to provide financial assistance in the form of fellowships and training opportunities to physician assistants who are participants in any such programs and who plan to teach or conduct research in a family medicine, general internal medicine, or general pediatrics training program;

”(F) to plan, develop, and operate a physician assistant education program, and for the training and certification of physician assistants who will teach in programs to provide such training;

”(G) to plan, develop, and operate a demonstration program that provides training in needed competencies, as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Workforce Commission in section 270S of the Patient Protection and Affordable Care Act, which may include—

“(B) be available for involuntary calls to active duty during national emergencies and public health crises, similar to the uniformed service reserve personnel;
“(1) providing training to primary care physicians relevant to providing care through patient-centered medical homes (as defined by the Secretary for purposes of this subsection); and

“(ii) developing tools and curricula relevant to patient-centered medical homes; and

“(iii) providing continuing education to primary care physicians relevant to patient-centered medical homes; and

“(H) to plan, develop, and operate joint degree programs to provide interdisciplinary and interprofessional graduate training in public health and other health professions to provide training in environmental health, infection control, disease prevention and health promotion, epidemiological studies and injury control.

“(2) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

“(b) Capacity Building in Primary Care.—

“(1) In general.—The Secretary may make grants or contracts under this subsection to accredited schools of medicine or osteopathic medicine to establish, maintain, or improve—

“(A) academic units or programs that improve clinical teaching and research in fields defined in subsection (a)(1)(A); or

“(B) programs that integrate academic administrative units defined in subsection (a)(1)(A) to enhance interdisciplinary recruitment, training, and faculty development.

“(2) Preference in making awards under this subsection.—In making awards of grants and contracts under paragraph (1), the Secretary shall give preference to any qualified applicant for such an award that agrees to expend the award for the purpose of—

“(A) establishing academic units or programs in fields defined in subsection (a)(1)(A); or

“(B) substantially expanding such units or programs.

“(3) Priorities in making awards.—In awarding grants or contracts under paragraph (1), the Secretary shall give priority to qualified applicants that—

“(A) proposes a collaborative project between academic administrative units of primary care;

“(B) proposes innovative approaches to clinical teaching using models of primary care, such as the patient-centered medical home, team management of chronic disease, and interprofessional integrated models of health care that incorporate transitions in health care settings and integration physical and mental health provision;

“(C) have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers who enter and remain in primary care practice;

“(D) have a record of training individuals who are from underserved minority groups, or from a rural or disadvantaged background;

“(E) provide training in the care of vulnerable populations such as children, older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with HIV/AIDS, and individuals with disabilities;

“(F) establish formal relationships and submit joint applications with federally qualified health centers, rural health clinics, area health education centers, and organizations located in underserved areas or that serve underserved populations;

“(G) teach trainees the skills to provide interprofessional, integrated care through collaboration among health professionals;

“(H) provide training in enhanced communication skills, chronic disease management, preventive care, health information technology, or other competencies as recommended by the Advisory Committee on Primary Care Medicine and Dentistry and the National Health Care Workforce Commission established in section 4101 of the Patient Protection and Affordable Care Act; and

“(I) provide training in cultural competency and health literacy.

“(4) Duration of awards.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

“(c) Authorization of Appropriations.—

“(1) In general.—For purposes of carrying out this section (other than subsection (b)(1)(B)), there are authorized to be appropriated $125,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014.

“(2) Training programs.—Fifteen percent of the amount appropriated pursuant to paragraph (1) of this subsection shall be allocated to the physician assistant training programs described in subsection (a)(1)(F), which prepare students for practice in primary care.

“(3) Integrating Academic Administrative Units.—For purposes of carrying out subsection (b)(1)(B), there are authorized to be appropriated $750,000 for each of fiscal years 2010 through 2014.”.  

SEC. 4302. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

Part C of Title VII of the Public Health Service Act (42 U.S.C. 296k et seq.) is amended by inserting after section 747, as amended by section 4301, the following:

“SEC. 747A. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

“(a) In general.—The Secretary shall award grants to eligible entities to enable such entities to provide new training opportunities for direct care workers who are employed in long-term care settings such as nursing homes (as defined in section 102 of the Higher Education Act of 1965 (20 U.S.C. 102)); assisted living facilities; and skilled nursing facilities, intermediate care facilities for individuals with mental retardation, residential care facilities for the mentally ill or mentally retarded, and continuing care retirement communities and, any other setting the Secretary determines to be appropriate.

“(b) Eligibility.—To be eligible to receive a grant under this section, an entity shall—

“(1) be an institution of higher education (as defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1012)) that—

“(A) is accredited by a nationally recognized accrediting agency or association listed under section 101(c) of the Higher Education Act of 1965 (20 U.S.C. 1012); and

“(B) has established a public-private educational partnership with a nursing home or skilled nursing facility, agency or entity providing home and community based services to individuals with disabilities, or other long-term care provider; and

“(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(c) Use of Funds.—An eligible entity shall use amounts awarded under a grant under this section to provide assistance to eligible individuals to offset the cost of tuition and required fees for enrollment in academic programs provided by such entity.

“(d) Eligibility.—To be eligible for assistance under this section, an individual shall

“(1) individuals agree to serve full-time as faculty members; and

“(2) CONDITION OF ASSISTANCE.—As a condition of receiving assistance under this section, an individual shall agree that, following completion of the assistance period, the individual will work in the field of geriatric, long term care, or chronic care management for a minimum of 2 years under guidelines set by the Secretary.

“(e) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section, $10,000,000 for the fiscal years 2011 to 2014.

SEC. 4303. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

Part C of Title VII of the Public Health Service Act (42 U.S.C. 296k et seq.) is amended by—

“(1) redesignating section 748, as amended by section 4103 of this Act, as section 749; and

“(2) inserting after section 747A, as added by section 4302, the following:

“SEC. 748. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

“(a) Support and Development of Dental Training Programs.—

“(1) In general.—The Secretary may make grants to, or enter into contracts with, a school of dentistry, public or nonprofit private hospital, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant or contract—

“(A) to plan, develop, and operate, or participate in, an approved professional training program in the field of dental hygiene, pediatric dentistry, or public health dentistry for dental students, residents, practicing dentists, or other approved primary care dental trainees, that emphasizes training for general, pediatric, or public health dentistry;

“(B) to provide financial assistance to dental students, residents, practicing dentists, and dental hygiene students who are in need thereof, who are participants in any such program, and who plan to work in the practice of general, pediatric, public health dentistry, or dental hygiene;

“(C) to plan, develop, and operate a program of the training of oral health care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene;

“(D) to provide financial assistance in the form of traineeships and fellowships to dentists who plan to teach or are teaching in general, pediatric, or public health dentistry; and

“(E) to provide the costs of projects to establish, maintain, or improve dental faculty development programs in primary care (which may be departments, divisions or other units);

“(F) to meet the costs of projects to establish, maintain, or improve predoctoral and postdoctoral training in primary care programs;

“(G) to create a loan repayment program for faculty in dental programs; and

“(H) to provide technical assistance to dental training programs in improving and implementing instruction regarding the oral health status, dental care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.

“(2) Faculty Loan Repayment.—

“(A) In general.—A grant or contract under subsection (a) may be awarded to a program of general, pediatric, or public health dentistry described in this subsection to plan, develop, and operate a loan repayment program for dental faculty who—

“(i) individuals agree to serve full-time as faculty members; and

“SEC. 4304. TRAINING IN PRIMARY CARE AND PUBLIC HEALTH PROTECTION.

There is authorized to be appropriated to carry out this section, $10,000,000 for the fiscal years 2011 to 2014.

SEC. 4305. TRAINING IN PRIMARY CARE AND PUBLIC HEALTH DENTISTRY.

There is authorized to be appropriated to carry out this section, $10,000,000 for the fiscal years 2011 to 2014.

SEC. 4306. TRAINING IN PEDIATRIC, PUBLIC HEALTH AND DENTISTRY.

There is authorized to be appropriated to carry out this section, $10,000,000 for the fiscal years 2011 to 2014.

SEC. 4307. TRAINING IN PRIMARY CARE AND PUBLIC HEALTH PROTECTION.

There is authorized to be appropriated to carry out this section, $10,000,000 for the fiscal years 2011 to 2014.
“(ii) the program of general, pediatric or public health dentistry agrees to pay the principal and interest on the outstanding balance as calculated based on principal and interest owed at the initiation of the agreement.

“(b) ELIGIBLE ENTITY.—For purposes of this subsection, an eligible entity shall include any educational institution that has programs in dental or dental hygiene school that are approved by the educational agencies or accrediting or reaccrediting or advanced education programs in the practice of general, pediatric, or public health dentistry. Eligible entities may partner with schools of public health to permit the education of dental students, residents, and dental hygiene students for a master’s year in public health at a school of public health.

“(c) Use of Funds.—With respect to training provided for under this section, the Secretary shall give priority in awarding grants or contracts to the following:

“(1) Qualified applicants that propose collaborative projects between departments of primary care medicine and departments of general, pediatric, or public health dentistry.

“(2) Qualified applicants that have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers, who enter and remain in general, pediatric, or public health dentistry.

“(3) Qualified applicants that have a record of training individuals who are from a rural or disadvantaged background, or from underrepresented minorities.

“(4) Qualified applicants that establish formal relationships with Federally qualified health centers, rural health centers, or accredited teaching facilities and that conduct training of students, residents, fellows, or faculty at the center or facility.

“(5) Qualified applicants that conduct teaching programs targeting vulnerable populations, such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and individuals with risk-based clinical disease management of all populations.

“(6) Qualified applicants that include educational activities in cultural competency and health literacy.

“(7) Qualified applicants that have a high rate for placing graduates in practice settings in underserved areas or health disparity populations, or who achieve a significant increase in the rate of placing graduates in such settings.

“(8) Qualified applicants that intend to establish a special populations oral health care education center or training program for the didactic and clinical education of dentists, dental hygienists, supervised dental hygienists, independent dental hygienists, dental therapists, dental assistants, dental laboratory technicians, dental health aides, and any other health professional that the Secretary determines appropriate.

“(b) Timeframe.—The demonstration projects funded under this section shall begin not later than 2 years after the date of enactment of this section, and shall conclude not later than 7 years after such date of enactment:

“(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a), an entity shall—

“(1) be—

“(A) an institution of higher education, including a community college;

“(B) a public hospital;

“(C) a federally qualified health center;

“(D) an Indian Health Service facility or a tribe or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act);

“(E) a State or county public health clinic, a health facility operated by an Indian tribe or tribal organization, or urban Indian organization providing dental services; or

“(P) a public hospital or health system;

“(2) be within a program accredited by the Commission on Dental Accreditation or within a dental education program in an accredited institution; and

“(3) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

“(d) ADMINISTRATIVE PROVISIONS.—

“(1) AMOUNT OF GRANT.—Each grant under this section shall be in an amount that is not less than $4,000,000 for the 5-year period during which the demonstration project is being conducted.

“(2) DISBURSEMENT OF FUNDS.—

“(A) PRELIMINARY DISBURSEMENTS.—Beginning 1 year after the enactment of this section, any eligible entity receiving a grant under this section not more than 20 percent of the total funding awarded to such entity under such grant, for the purpose of enabling the entity to plan the demonstration project to be conducted under such grant.

“(B) SUBSEQUENT DISBURSEMENTS.—The remaining amount of grant funds not dispersed under subparagraph (A) shall be dispersed such that not less than 15 percent of such remaining amount is dispersed each subsequent year.

“(e) COMPLIANCE WITH STATE REQUIREMENTS.—Each entity receiving a grant under this section shall certify that it is in compliance with all applicable State licensing requirements.

“(f) EQUITY.—The Secretary shall contract with the Director of the Institute of Medicine to conduct a study of the demonstration programs conducted under this section that shall provide analysis, based upon quantitative and qualitative data, regarding access to dental health care in the United States.

“Sec. 4305. GERIATRIC EDUCATION AND TRAINING; CAREER AWARDS; COMPREHENSIVE GERIATRIC EDUCATION.

“(a) WORKFORCE DEVELOPMENT; CAREER AWARDS.—Section 753 of the Public Health Service Act (42 U.S.C. 294c) is amended by adding at the end the following:

“(4) GERIATRIC EDUCATION; CAREER AWARDS.—

“(1) In General.—The Secretary shall award grants or contracts under this subpart to entities that operate a geriatric education center pursuant to subsection (a)(1).

“(2) Application.—To be eligible for an award under paragraph (1), an entity described in such paragraph shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(3) Use of Funds.—Funds awarded under a grant or contract under paragraph (1) shall be used to—

“(A) carry out the fellowship program described in paragraph (3); and

“(B) carry out 1 of the 2 activities described in paragraph (5).

“(4) FELLOWSHIP PROGRAM.—In general.—Pursuant to paragraph (3), a geriatric education center that receives an award under this subsection shall use such funds to offer short-term intensive courses (referred to in this subsection as a ‘fellowship’) that focus on geriatrics, chronic care management, and long-term care that provide supplemental training for faculty members from medical schools and other health professions schools with programs in psychology, pharmacy, nursing, social work, dentistry, public health, allied health, or other health disciplines, as approved by the Secretary. Such a fellowship shall be open to current faculty, and appropriately credentialed volunteer faculty and practitioners, who do not have formal training in geriatrics, to upgrade their knowledge and clinical skills for the care of older adults and adults with functional limitations and to enhance their interdisciplinary skills.

“(B) LOCATION.—A fellowship shall be offered either at the geriatric education center that is sponsoring the course, in collaboration with other geriatric centers, or at medical schools, schools of dentistry, schools of nursing, schools of pharmacy, ...
schools of social work, graduate programs in psychology, or allied health and other health professions schools approved by the Secretary with which the geriatric education center is affiliated.

"(C) CME CREDIT.—Participation in a fellowship under this paragraph shall be accepted with respect to complying with continuing education requirements.

As a condition of such acceptance, the recipient shall agree to subsequently provide a minimum of 18 hours of voluntary instruction to one or more accredited geriatric education centers that is providing clinical training to students or trainees in long-term care settings.

"(5) ADDITIONAL REQUIRED ACTIVITIES DESCRIBED.—Pursuant to paragraph (3), a geriatric education center that receives an award under this subsection shall use such funds to carry out 1 of the following 2 activities.

(A) FAMILY CAREGIVER AND DIRECT CARE PROVIDER TRAINING.—A geriatric education center that receives an award under this subsection shall offer at least 2 courses each year, at no charge or nominal cost, to family caregivers and direct care providers that are designed to provide practical training for supporting frail elders and individuals with disabilities. The Secretary shall require such centers to identify appropriate community partners to develop training program content and to publicize the availability of training courses in the service areas. All family caregivers and direct care provider training programs shall include instruction on the management of psychological and behavioral aspects of dementia, communication techniques for working with individuals who have dementia, and the appropriate, safe, and effective use of medications for older adults.

(B) INSTRUCTION OF HIGHEST PRACTICE.—A geriatric education center that receives an award under this subsection shall develop and implement a comprehensive program to develop, support, and maintain a faculty and staff that will provide exemplary care and services to older adults.

"(6) TARGETS.—A geriatric education center that receives an award under this subsection shall meet targets approved by the Secretary for providing geriatric training to a certain number of faculty or practitioners during the term of the award, as well as other parameters established by the Secretary.

"(7) AMOUNT OF AWARD.—An award under this subsection shall be in an amount of $150,000. Not more than 24 geriatric education centers may receive an award under this subsection.

"(8) MAINTENANCE OF EFFORT.—A geriatric education center that receives an award under this subsection shall provide assurances that funds provided to the geriatric education center under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.

"(2) ELIGIBLE INDIVIDUALS.—To be eligible to receive an award under paragraph (1), an individual shall—

(A) either be a geriatrician or be a health professional in geriatrics, including geriatric subspecialties, or be a health professional who is engaged in the care of older adults;

(B) have at least 2 years of experience in geriatrics or the care of older adults;

(C) be employed by, or have a practicing affiliation with, a geriatric education center that is providing clinical training to students or trainees in long-term care settings; and

(D) have demonstrated excellence in geriatrics or the care of older adults.

"(3) MAINTENANCE OF EFFORT.—An eligible individual that receives an award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.

"(3) MAINTENANCE OF EFFORT.—An eligible individual that receives an award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.

"(3) MAINTENANCE OF EFFORT.—An eligible individual that receives an award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.

"(3) MAINTENANCE OF EFFORT.—An eligible individual that receives an award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.

"(3) MAINTENANCE OF EFFORT.—An eligible individual that receives an award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.

"(3) MAINTENANCE OF EFFORT.—An eligible individual that receives an award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.

"(3) MAINTENANCE OF EFFORT.—An eligible individual that receives an award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.

"(3) MAINTENANCE OF EFFORT.—An eligible individual that receives an award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.

"(3) MAINTENANCE OF EFFORT.—An eligible individual that receives an award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.

"(3) MAINTENANCE OF EFFORT.—An eligible individual that receives an award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.

"(3) MAINTENANCE OF EFFORT.—An eligible individual that receives an award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.

"(3) MAINTENANCE OF EFFORT.—An eligible individual that receives an award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.

"(3) MAINTENANCE OF EFFORT.—An eligible individual that receives an award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.

"(3) MAINTENANCE OF EFFORT.—An eligible individual that receives an award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.

"(3) MAINTENANCE OF EFFORT.—An eligible individual that receives an award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.
religious, linguistic, and class backgrounds, and different genders and sexual orientations;

(2) knowledge and understanding of the concerns of individuals and groups described in subsection (a);

(3) at least 4 of the grant recipients shall be historically black colleges or universities or other minority-serving institutions.

(4) the institution will provide to the Secretary such data, assurances, and information as may be necessary to determine the extent to which the agreement has been met.

(5) with respect to any violation of the agreement between the Secretary and the institution, the institution will pay such liquidated damages as prescribed by the Secretary by regulation.

(c) INSTITUTIONAL REQUIREMENT.—For grants authorized under subsection (a)(1), at least 4 of the grant recipients shall be historically black colleges or universities or other minority-serving institutions.

(d) Priority.—

(1) In selecting the grant recipients in social work under subsection (a)(1), the Secretary shall give priority to applicants that—

(A) are accredited by the Council on Social Work Education;

(B) have a graduation rate of not less than 80 percent for social work students; and

(C) exhibit an ability to recruit social workers from and place social workers in areas with a high need and high demand population.

(2) In selecting the grant recipients in graduate psychology under subsection (a)(2), the Secretary shall give priority to institutions in which training focuses on the needs of vulnerable groups such as older adults and children, individuals with mental health or substance-related disorders, victims of abuse or trauma and of combat stress disorders such as posttraumatic stress disorder and traumatic brain injuries, homeless individuals, chronically ill persons, and their families.

(3) In selecting the grant recipients in training programs in child and adolescent mental health under subsections (a)(3) and (a)(4), the Secretary shall give priority to applicants that—

(A) have demonstrated the ability to collect data on the number of students trained in child and adolescent mental health and the populations served by such students after graduation or completion of preservice or in-service training;

(B) have demonstrated familiarity with evidence-based methods in child and adolescent mental health services, including substance abuse prevention and treatment services;

(C) have programs designed to increase the number of professionals and paraprofessionals serving high-priority populations and to applicants who come from high-priority communities and plan to serve medically underserved populations, in health professional shortage areas, or in medically underserved areas;

(D) offer curriculum taught collaboratively with a family on the consumer and family lived experience or the importance of family-professional or family-paraprofessional partnerships; and

(E) provide services through a community mental health program described in section 1915(b)(1).

(e) AUTHORIZATION OF APPROPRIATION.—For the fiscal years 2010 through 2013, there is authorized to be appropriated to carry out this section—

(1) $5,000,000 for training in social work in subsection (a)(1); and

(2) $12,000,000 for training in graduate psychology in subsection (a)(2), of which not less than $10,000,000 shall be allocated for doctoral, postdoctoral, and internship level training;

(3) $10,000,000 for training in professional child and adolescent mental health in subsection (a)(3); and

(4) $5,000,000 for training in paraprofessional child and adolescent work in subsection (a)(4).

(b) CONFORMING AMENDMENTS.—Section 757(b)(2) of the Public Health Service Act, as redesignated by subsection (a), is amended by inserting “sections 751a(1)(A), 751a(1)(B), 753(b), 754(3)(A), and 755(b)” and inserting “sections 751b(1)(A), 753b, and 755b(b)”.

(c) SEC. 4307. CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITIES; AND NURSE MIDWIFERY PROGRAMS.

(a) TITLE VII.—Section 741 of the Public Health Service Act (42 U.S.C. 296e) is amended—

(1) in subsection (a)—

(A) by striking the subsection heading and inserting “CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITY GRANTS”; and

(B) in paragraph (1), by striking “for the purpose of” and all that follows through the period at the end and inserting “for the development, evaluation, dissemination, and coordination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and increasing cultural competency, for working with individuals with disabilities training for use in health professions schools and continuing education programs; and funding purposes determined as appropriate by the Secretary.”;

(2) In selecting the grant recipients in professional partnerships; and

(f) COLLABORATION.—In carrying out subsection (a), the Secretary shall collaborate with health professional societies, licensing and accreditation entities, health professions schools, and experts in minority health and cultural competency, prevention, and public health and disability groups, community-based organizations, and other organizations as determined appropriate by the Secretary.

SEC. 4308. ADVANCED NURSING EDUCATION GRANTS.

Section 811 of the Public Health Service Act (42 U.S.C. 296e) is amended—

(1) in subsection (c)—

(A) in the subsection heading, by striking “and Nurse Midwifery Programs” and inserting “and Nurse Midwifery Programs”; and

(B) by striking “and nurse midwifery”;

(2) in subsection (d), by striking paragraph (2); and

(3) by redesignating paragraph (3) as paragraph (2); and

(b) IN GENERAL.—Section 831 of the Public Health Service Act (42 U.S.C. 296e-1) is amended—

(1) in subsection (a)—

(A) by striking the subsection heading and inserting “CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITY GRANTS”; and

(B) by striking “for the purpose of” and all that follows through “health care.” and inserting “and cultural competency, prevention, public health proficiency, reducing health disparities, and increasing cultural competency, for working with individuals with disabilities training for use in health professions schools and continuing education programs; and funding purposes determined as appropriate by the Secretary.”;

(2) by striking subsection (b) and inserting the following:

(b) COLLABORATION.—In carrying out subsection (a), the Secretary shall collaborate with health professional societies, licensing and accreditation entities, health professions schools, and experts in minority health and cultural competency, prevention, and public health and disability groups, community-based organizations, and other organizations as determined appropriate by the Secretary. The Secretary shall coordinate with curricula and research and demonstration projects developed under this section.

(c) SEC. 4309. NURSE EDUCATION, PRACTICE, AND RETENTION.

(a) TITLE.—Section 870 of the Public Health Service Act (42 U.S.C. 296b) is amended—

(1) in subsection (c)—

(A) by striking “coordinated care” and inserting “coordinated care, quality improvement” and inserting “coordinated care,” and

(B) by striking paragraph (3); and

(2) by redesigning paragraph (3) as paragraph (2);

(3) by redesigning subsections (d), (e), and (f) as subsections (e), (f), and (g), respectively; and

(4) by inserting after subsection (c), the following:

(d) AUTHORIZED NURSE MIDWIFERY PROGRAMS.—Midwifery programs that are eligible for support under this section are educational programs that—

(1) have as their objective the education of midwives; and

(2) are accredited by the American College of Nurse-Midwives Accreditation Commission for Midwifery Education.”.

(b) SEC. 4309. NURSE EDUCATION, PRACTICE, AND RETENTION.

(1) in the section heading, by striking “RE- TENTION” and inserting “QUALITY”;

(b) SEC. 4310. NURSE RETENTION GRANTS.—Title VIII of the Public Health Service Act is amended by inserting after section 831 (42 U.S.C. 296b) the following:

“SEC. 831A. NURSE RETENTION GRANTS.

(a) RETENTION PRIORITY AREAS.—The Secretary may award grants to, and enter into contracts with, eligible entities to enhance the nursing workforce by initiating and maintaining nurse retention programs pursuant to subsection (b) through (c).

(b) GRANTS FOR CAREER LADDER PROGRAM.—The Secretary may award grants to,
and enter into contracts with, eligible entities for programs—

(1) to promote career advancement for individuals including licensed practical nurses, licensed vocational nurses, or registered nurses in order to meet the needs of the registered nurse workforce;

(2) developing and implementing internships and residency programs in collaboration with an accredited school of nursing, as defined by section 801(2), to encourage mentoring and the development of specialties; or

(3) to assist individuals in obtaining education and training required to enter the nursing profession and advance within such profession.

(c) ENHANCING PATIENT CARE DELIVERY SYSTEMS.

(1) GRANTS.—The Secretary may award grants to eligible entities to improve the retention of nurses and enhance patient care that is directly related to nursing activities through collaboration and communication between nurses and other health care professionals and nursing improvement in the organizational and clinical decision-making processes of a health care facility.

(2) PRIORITY.—In making awards of grants under this subsection, the Secretary shall give preference to applicants that have not previously received an award under this subsection or such other entities as the Secretary may determine, except that no grant shall be awarded to a recipient that is receiving an award under this part.

(3) CONTINUATION OF AN AWARD.—The Secretary shall award an extension of the grant under this subsection beyond the second year of such award contingent on the recipient of such award having demonstrated to the Secretary measurable and substantive improvement in nursing retention or patient care.

(d) OTHER PRIORITY AREAS.—The Secretary may award grants to, or enter into contracts with, eligible entities to address the needs of the registered nurse workforce; advanced education nurses in order to meet the needs of the registered nurse workforce; and redesignating such part as part I; and

(9) in part H—

(7) by redesignating section 841 as section 839; and

(8) in section 835(b), by striking ‘‘is entitled’’ and inserting ‘‘a 6-year period beginning on the date the United States becomes so entitled’’;

(10) in section 836, by redesignating subsection (a) as subsection (c), and redesignating parts C, and D (subject to section 851(g), there are no sections 851(g), 852, and 853), and redesignating such part as part I; and

(11) in section 837, by redesignating section 846A as section 835.

SEC. 4310. LOAN REPAYMENT AND SCHOLARSHIP PROGRAM.

(a) LOAN REPAYMENTS AND SCHOLARSHIPS.—Section 964(a)(3) of the Public Health Service Act (42 U.S.C. 296d–3(3)) is amended—

(1) in section 836, by striking ‘‘30,000’’ and inserting ‘‘$30,000’’;

(2) in section 836, by redesignating section 846A as section 839, and moving such section so that it follows section 846A, as redesignated and moved by section 4243, a health care facility, or a program of education as described in section 846A, as amended—

(1) not more than 10 months after the date on which the 6-year period described in paragraph (1) shall be paid to the United States Government is entitled to recover under the agreement terms required under such subsection.

(2) WAIVER OR SUSPENSION OF LIABILITY.—In the case of an eligible individual under any agreement for purposes of paragraph (1), the Secretary may award for the waiver or suspension of liability under such paragraph if compliance by the individual with the agreement terms involved is impossible or would involve extreme hardship to the individual or if enforcement of the agreement with respect to the individual would be financially infeasible.

(3) DATE CERTAIN FOR RECOVERY.—Subject to paragraph (2), any amount that the Federal Government is entitled to recover under paragraph (1) shall be paid to the United States not later than the expiration of the 3-year period beginning on the date the United States becomes so entitled.

(4) AVAILABILITY.—Amounts recovered under paragraph (1) shall be available to the Secretary for making loan repayments under this section and shall remain available for such purpose until expended.

SEC. 4312. AUTHORIZATION OF APPROPRIATIONS FOR PARTS B THROUGH D OF TITLE VIII.

Section 871 of the Public Health Service Act, as redesignated and moved by section 4210, is amended to read as follows:

(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out parts B, C, and D (subject to section 851(c)), there are provided to the Secretary for making loan repayments under this section and shall remain available for such purpose until expended.
authorized to be appropriated $338,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2016."

SEC. 4313. GRANTS TO PROMOTE THE COMMUNITY HEALTH WORKFORCE.

(a) In General.—Part P of title III of the Public Health Service Act (42 U.S.C. 288a et seq.) is amended by adding at the end the following:

``SEC. 399V. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS AND OUTCOMES.

``(a) Grants Authorized.—The Director of the Centers for Disease Control and Prevention, in consultation with the Secretary, shall award grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.

``(b) Use of Funds.—Grants awarded under subsection (a) shall be used to support community health workers—

``(1) to educate, guide, and provide outreach in a community setting regarding health that is prevalent in medically underserved communities, particularly racial and ethnic minority populations;

``(2) to educate and provide guidance regarding strategies to promote positive health behaviors and discourage risky health behaviors;

``(3) to identify, educate, refer, and enroll underserved populations to appropriate healthcare agencies and community-based programs and organizations in order to increase access to quality healthcare services and to eliminate duplicative care; or

``(4) to educate, guide, and provide home visitation services regarding maternal health and pregnancy.

``(c) Application.—Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary may require.

``(d) Priority.—In awarding grants under subsection (a), the Secretary shall give priority to applicants that—

``(1) propose to target geographic areas—

``(A) with a high percentage of residents who suffer from chronic diseases; or

``(B) with a high infant mortality rate; or

``(2) have experience in providing health or healthcare services to a community of individuals who are underserved with respect to such services; and

``(3) have documented community activity and experience with community health workers.

``(e) Collaboration with Academic Institutions and the One-Stop Delivery System.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions and one-stop delivery systems under section 13(c) of the Workforce Investment Act of 1998. Nothing in this section shall be construed to require such collaboration.

``(f) Evidence-Based Interventions.—The Secretary shall encourage community health worker programs receiving funding under this section to implement a process or an outcome-based payment system that rewards community health workers for connecting underserved populations with the most appropriate services at the most appropriate time. Nothing in this section shall be construed to require such a payment.

``(g) Insurance and Cost Effectiveness.—The Secretary shall establish guidelines for assuring the quality of the training and supervision of community health workers, in the programs receiving funds under this section and for assuring the cost-effectiveness of such programs.

``(b) Monitoring.—The Secretary shall monitor community health worker programs identified in approved applications under this section and shall determine whether such programs are in compliance with the guidelines established under subsection (g).

``(i) Technical Assistance.—The Secretary may provide technical assistance to community health worker programs identified in approved applications under this section with respect to planning, developing, and operating programs under the grant.

``(j) Authorization of Appropriations.—There are authorized to be appropriated, such sums as may be necessary to carry out this section for each of fiscal years 2010 through 2014.

``(k) Definitions.—In this section:

``(1) COMMUNITY HEALTH WORKER.—The term ‘community health worker’, as defined by the Department of Labor as Standard Occupational Classification [21–1094] means an individual who promotes health or nutrition within the community in which the individual resides—

``(A) by serving as a liaison between communities and healthcare agencies; or

``(B) by providing social assistance to community residents;

``(C) by enhancing community residents’ ability to effectively communicate with healthcare providers; or

``(D) by providing culturally and linguistically appropriate health or nutrition education;

``(E) by advocating for individual and community health;

``(F) by providing referral and follow-up services or otherwise coordinating care; and

``(G) by working individually and enrolling eligible individuals in Federal, State, local, private or nonprofit health and human services programs.

``(2) COMMUNITY SETTINGS.—The term ‘community setting’ means a home or a community organization located in the neighborhood in which a participant in the program under this section resides.

``(3) ELIGIBLE ENTITY.—The term ‘eligible entity’ means a public or nonprofit private entity (including a State or public subdivision of a State, a public health department, a free health clinic, a hospital, or a Federally-qualified health center (as defined in section 1386(aa) of the Social Security Act)), an academic institution, or a community-based organization.

``(4) MEDICALLY UNDERSERVED COMMUNITY.—The term ‘medically underserved community’ means a community identified by a State—

``(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 398(b)(3); and

``(B) a significant portion of which is a health professional shortage area as designated under section 332.

``(4) FELLOWSHIP TRAINING IN PUBLIC HEALTH.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.), as amended by section 429b, is further amended by adding at the end the following:

``SEC. 778. FELLOWSHIP TRAINING IN APPLIED PUBLIC HEALTH EPIDEMIOLOGY, PUBLIC HEALTH LABORATORY SCIENCE, PUBLIC HEALTH INFORMATICS, AND EXPANSION OF THE EPIDEMIC INTELLIGENCE SERVICE.

``(a) In General.—The Secretary may carry out, in collaboration with the National Health Care Workforce Commission established in section 4101 of the Patient Protection and Affordable Care Act, programs to train public health professionals and expand the Epidemic Intelligence Service.

``(b) Specific Uses.—In carrying out subsection (a), the Secretary shall provide for the expansion of existing fellowship programs operated through the Centers for Disease Control and Prevention, in a manner that is designed to alleviate shortages of the type described in subsection (a).

``(c) Other Programs.—The Secretary may provide for the expansion of existing applied epidemiology training programs that meet objectives similar to the objectives of the programs described in subsection (b).

``(d) Work Obligation.—Participation in fellowship training programs under this section shall be deemed to be service for purposes of satisfying work obligations stipulated in section 332.

``(e) General Support.—Amounts may be used from grants awarded under this section to expand the Public Health Informatics Fellowship Program at the Centers for Disease Control and Prevention to better support all public health systems at all levels of government.

``(f) Authorization of Appropriations.—There are authorized to be appropriated to carry out this section $9,500,000 for each of fiscal years 2011 through 2014."

``(g) Authorization of Appropriations.—There are authorized to be appropriated $5,000,000 in each such fiscal year for epidemiology fellowship training programs under subsection (b).

``(h) Authorization of Appropriations.—There are authorized to be appropriated in each such fiscal year for public health informatics fellowship programs under subsection (e); and

``(i) $24,500,000 shall be made available for expanding the Epidemic Intelligence Service under subsection (a)."

SEC. 4315. UNITED STATES PUBLIC HEALTH SCIENCES TRACK

``SEC. 271. ESTABLISHMENT.

``(a) United States Public Health Sciences Track.—

``(1) IN GENERAL.—There is hereby authorized to be established a United States Public Health Sciences Track (referred to in this part as the ‘Track’), at sites to be selected by the Secretary, which shall provide appropriate advanced degrees in a manner that uniquely emphasizes team-based service, public health, epidemiology, and emergency preparedness and response. It shall be so organized as to graduate not less than—

``(A) 150 medical students annually, 10 of whom shall be awarded studentships to the Uniformed Services University of Health Sciences;

``(B) 100 dental students annually;

``(C) 250 nursing students annually;

``(D) 100 public health students annually;

``(E) 100 behavioral and mental health professional students annually;

``(F) 100 physician assistant or nurse practitioner students annually; and

``(G) 50 pharmacy students annually.

``(2) Locations.—The Track shall be located at existing and accredited, affiliated health professions educational programs at academic health centers located in regions of the United States determined appropriate by the Surgeon General, in consultation with the National Health Care Workforce Commission established in section 4101 of the Patient Protection and Affordable Care Act.

``(3) Number of Graduates.—Except as provided in subsection (a), the number of persons to be graduated from the Track shall

``(b) Authorization of Appropriations.—There are authorized to be appropriated $9,500,000 for each of fiscal years 2011 through 2014.
be prescribed by the Secretary. In so prescribing the number of persons to be graduated from the Track, the Secretary shall institute actions necessary to ensure the maximum number of eligible year-end enrollees shall be graduates of the Track consistent with the academic capacity of the affiliated sites and the needs of the United States for medical, dental, and nursing students.

"(c) DEVELOPMENT.—The development of the Track may be by such phases as the Secretary may prescribe subject to the requirements of subsection (a).

"(d) INTEGRATED LONGITUDINAL PLAN.—The Surgeon General shall develop an integrated longitudinal plan for health professions continuing education throughout the continuum of health-related education, training, and practice. Training under such plan shall emphasize patient-centered, interdisciplinary, and care coordination skills. Experience with deployment of emergency response teams shall be included during the clinical experiences.

"(e) FACULTY DEVELOPMENT.—The Surgeon General shall develop faculty development programs and curricula in decentralized venues of health care, to balance urban, tertiary, and rural needs.

"SEC. 272. ADMINISTRATION.

"(a) IN GENERAL.—The business of the Track shall be conducted by the Surgeon General in accordance with regulations prescribed by the Secretary of Health and Human Services. The National Health Care Workforce Commission shall assume the Surgeon General's functions in an advisory capacity.

"(b) FACULTY.—

"(1) IN GENERAL.—The Surgeon General, after considering the recommendations of the National Health Care Workforce Commission, shall obtain the services of such professors, instructors, and administrative and other employees as may be necessary to operate the Track and to utilize when possible, other employees as may be necessary to operate the affiliated institutions. Members of the faculty and staff shall be employed under salary schedules and granted retirement and other related benefits prescribed by the Secretary so as to place the employees of the Track faculty on a comparable basis with the employees of schools of health professions within the United States.

"(2) TITLES.—The Surgeon General may confer academic titles, as appropriate, upon the medical, dental, or nursing faculty and staff.

"(3) NONAPPLICATION OF PROVISIONS.—The limitations in section 3573 of title 5, United States Code, shall not apply to the appointment of the Surgeon General, and the compensation of the Surgeon General, and the compensation of the Surgeon General of health professions training institutions. Members of the faculty and staff shall be employed under salary schedules and granted retirement and other related benefits.

"(c) AGREEMENTS.—The Surgeon General may negotiate agreements with agencies of the Federal Government to utilize on a reimbursable basis appropriate existing Federal medical resources located in the United States (or locations selected in accordance with section 271(a)(2)). Under such agreements the facilities concerned will retain their identities and basic missions. The Surgeon General may negotiate affiliation agreements with accredited universities and health professions training institutions in the United States. Such agreements may include provisions for payment for educational services provided students participating in Department of Health and Human Services educational programs.

"(d) CONTRACTS.—The Surgeon General may establish the following educational programs for Track students:

"(1) Postdoctoral, postgraduate, and technology programs for medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students; and

"(2) A cooperative program for medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students.

"(3) Other programs that the Surgeon General determines necessary in order to operate the Track in a manner consistent with the purposes for which the Track was established.
“(B) in the case of a student who, upon completion of their residency, elects to practice in a Federal medical facility (as defined in section 783(e)) that is located in a health professional shortage area (as defined in section 332), by 3 months for year of full-time practice in such a facility (not to exceed a total of 12 months).”

(3) USE OF FEDERAL FUNDS.—With respect to any Federal amounts received by a center of excellence and available for carrying out activities for which a grant under this part is authorized to be expended, the center shall, before expending the Federal amounts obtained from sources other than the grant, unless given prior approval from the Secretary, meet the requirements described in section 332(a)(1), is dropped from the program that are appropriate due to

(1) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(2) and such sums as are necessary for each subsequent fiscal year.

SEC. 4402. HEALTH PROFESSIONALS TRAINING FOR DIVERSITY.

(a) LOAN REPAYMENTS AND FELLOWSHIPS REGARDING FACULTY POSITIONS.—Section 748a(a) of the Public Health Service Act (42 U.S.C. 294a) is amended by striking “$20,000 of the principal and interest of the educational loans of such individuals.” and inserting “$30,000 of the principal and interest of the educational loans of such individuals.”.

(b) SCHOLARSHIPS FOR DISADVANTAGED STUDENTS.—Section 748a(b) of such Act (42 U.S.C. 294a) is amended by inserting “$30,000,000” and all that follows through “after grants are made” in section 332(a)(1), and is dropped from the program that are appropriate due to

(1) DROPPED FROM TRACK IN AFFILIATE SCHOOL.—A medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students who meet the conditions described in subsection (c)(5).

(2) FUNDING IN EXCESS OF $20,000,000.—If amounts appropriated under subsection (i) for fiscal year exceed $20,000,000 but are less than $30,000,000—

(3) FUNDING IN EXCESS OF $30,000,000.—If amounts appropriated under subsection (i) for a fiscal year exceed $30,000,000 but are less than $40,000,000, the Secretary shall make available—

(4) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2); and

(5) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

(6) and such sums as are necessary for each of the fiscal years 2010 through 2015; and

(7) DROPPED FROM TRACK IN FEDERAL DISASTER PREPAREDNESS TRAINING.—The Surgeon General shall establish and maintain an emergency fund of $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

(8) and such sums as are necessary for each of the fiscal years 2010 through 2015; and

(9) DROPPED FROM TRACK IN ACADEMIC INSTITUTIONS.—The Secretary shall make the following 2 types of awards in accordance with this section:

(1) INFRASTRUCTURE DEVELOPMENT AWARD.—The Secretary shall make awards to eligible entities to enable such entities to initiate health care workforce educational programs or to continue to carry out comparable programs that are operating at the time the award is made by planning, developing, operating, and evaluating an area health education center program.

(2) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT AWARD.—The Secretary shall make awards to eligible entities to maintain and improve the effectiveness and capabil-

SEC. 44003. INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES.

(a) AREA HEALTH EDUCATION CENTERS.—Section 751 of the Public Health Service Act (42 U.S.C. 294a) is amended by striking “$30,000,000” and all that follows through “after grants are made” in section 332(a)(1), and is dropped from the program that are appropriate due to

(2) and such sums as are necessary for each of the fiscal years 2010 through 2015; and

(3) DROPPED FROM TRACK IN ACADEMIC INSTITUTIONS.—The Secretary shall make the following 2 types of awards in accordance with this section:

(1) INFRASTRUCTURE DEVELOPMENT AWARD.—The Secretary shall make awards to eligible entities to enable such entities to initiate health care workforce educational programs or to continue to carry out comparable programs that are operating at the time the award is made by planning, developing, operating, and evaluating an area health education center program.

(2) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT AWARD.—The Secretary shall make awards to eligible entities to maintain and improve the effectiveness and capabil-

SEC. 44002. SUPPORTING THE EXISTING HEALTH CARE WORKFORCE.

SEC. 4401. CENTERS OF EXCELLENCE.

SEC. 4374. FUNDING.

“Beginning with fiscal year 2010, the Secretary shall transfer from the Public Health and Social Services Emergency Fund such sums as may be necessary to carry out this part.”

Subtitle E—Supporting the Existing Health Care Workforce

SEC. 4401. CENTERS OF EXCELLENCE.

Section 751 of the Public Health Service Act (42 U.S.C. 294a) is amended by striking “$30,000,000” and all that follows through “after grants are made” in section 332(a)(1), and is dropped from the program that are appropriate due to

(1) FORMULA FOR ALLOCATIONS.—(1) Formula for allocations—Based on the amount appropriated under subsection (i) for a fiscal year, the following subparagraphs shall apply as appropriate—

(2) and such sums as are necessary for each of the fiscal years 2010 through 2015; and

(3) DROPPED FROM TRACK IN ACADEMIC INSTITUTIONS.—The Secretary shall make the following 2 types of awards in accordance with this section:

(1) INFRASTRUCTURE DEVELOPMENT AWARD.—The Secretary shall make awards to eligible entities to enable such entities to initiate health care workforce educational programs or to continue to carry out comparable programs that are operating at the time the award is made by planning, developing, operating, and evaluating an area health education center program.

(2) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT AWARD.—The Secretary shall make awards to eligible entities to maintain and improve the effectiveness and capabil-

SEC. 44003. INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES.

(a) AREA HEALTH EDUCATION CENTERS.—Section 751 of the Public Health Service Act (42 U.S.C. 294a) is amended by striking “$30,000,000” and all that follows through “after grants are made” in section 332(a)(1), and is dropped from the program that are appropriate due to

(2) and such sums as are necessary for each of the fiscal years 2010 through 2015; and

(3) DROPPED FROM TRACK IN ACADEMIC INSTITUTIONS.—The Secretary shall make the following 2 types of awards in accordance with this section:

(1) INFRASTRUCTURE DEVELOPMENT AWARD.—The Secretary shall make awards to eligible entities to enable such entities to initiate health care workforce educational programs or to continue to carry out comparable programs that are operating at the time the award is made by planning, developing, operating, and evaluating an area health education center program.

(2) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT AWARD.—The Secretary shall make awards to eligible entities to maintain and improve the effectiveness and capabil-
changes in demographics, needs of the popula-
tions served, or other similar issues affect-
ing the area health education center pro-
gram. For the purposes of this section, the term 'eligi-
bile entity' means an entity that has received funds under this sec-
tion, or is operating an area health education center program, including an area health education center or centers, and has a center or centers that are no longer eligible to receive financial assistance under subsection (a)(1).

(2) APPLICATION.—An eligible entity desiring to receive an award under this section shall submit to the Secretary an application at such time, in such manner, and contain-
ing such information as the Secretary may require.

(c) Use of Funds.—(1) REQUIREMENTS.—An eligible en-
tity shall use amounts awarded under a grant under subsection (a)(1) or (a)(2) to carry out the following activities:

(A) Develop and implement strategies, in coordination with the applicable one-stop delivery system under section 333(c) of the Workforce Investment Act of 1998, to recruit individuals from underrepresented minority populations or from disadvantaged or rural backgrounds into health professions, and support such individuals in attaining such careers.

(B) Develop and implement strategies to foster and provide community-based training and education to individuals seeking careers in health care within underserved areas for the purpose of developing and maintaining a diverse health care workforce that is prepared to deliver high-quality care, with a particular emphasis on primary care in underserved areas or for health disparity popu-
lations, in collaboration with other Federal and State health care workforce develop-
ment programs, such as workforce agency, and local workforce investment boards, and in health care safety net sites.

(C) Prepare individuals to more effec-
tively provide health services to underserved areas and health disparity populations through field placements or preceptorships in conjunction with community-based organiza-
tions, area health education center or primary care training programs. Federally qualified health centers, rural health clinics, public health departments, or other appropriate fac-
cilities.

(D) Conduct and participate in inter-
deriplinary training that involves physi-
cians, physician assistants, nurse prac-
titioners, nurse midwives, dentists, psychologists, pharmacists, optometrists, community health workers, public and allied health profes-
sionals, or other health professionals, as practic-
able.

(E) Deliver or facilitate continuing edu-
cation and information dissemination pro-
grams for health care professionals, with an emphasis on individuals providing care in underserved areas and for health disparity popu-
lations.

(F) Propose and implement effective pro-
gram and outcomes measurement and eval-
uation strategies.

(G) Establish a youth public health pro-
gram to encourage high school students to enter health careers, with a focus on ca-
careers in public health.

(3) INNOVATIVE OPPORTUNITIES.—An eligi-
bile entity may use amounts awarded under a grant under subsection (a)(1) or subsection (a)(2) to carry out any of the following ac-
tivities:

(A) Develop and implement innovative curricula in collaboration with community-based accredited primary care residency training programs to prepare students from that school in training sites in the geographic area or population served by the area health education center program.

(B) Coordinate community-based participatory research with academic health centers, and facilitate rapid flow and dissemina-
tion of health care information, research results, and best prac-
tices to improve quality, efficiency, and ef-fectiveness of health care and health systems with underserved populations.

(C) Develop and implement other strate-
gies to address identified workforce needs and increase and enhance the health care workforce in underserved areas by the area health education center program.

(d) REQUIREMENTS.—(1) AREA HEALTH EDUCATION CENTER PRO-
GRAM.—In carrying out this section, the Sec-

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Secretary shall ensure the following:

(A) An entity that receives an award under this section shall at least 10 percent of clinical education required for medical students in community settings that are removed from the primary teaching fa-
cility of the contracting institution for grantees that operate a school of medicine or osteopathic medicine. In States in which an entity that receives an award under this sec-
tion is a nursing school or its parent institu-
tion, the Secretary shall alternatively en-
sure that—

(i) the nursing school conducts at least 10 percent of clinical education required for nursing students in community settings that are remote from the primary teaching fa-
cility of the nursing school; and

(ii) the entity receiving the award main-
tains a written agreement with a school of medicine or osteopathic medicine to place students from that school in training sites in the area health education center program area.

(B) An entity receiving funds under sub-
section (a)(1) or (a)(2) to distribute such fund-
ing to a center that is eligible to receive funding under subsection (a)(1).

(2) AREA HEALTH EDUCATION CENTER.—The Secretary shall ensure that each area health education center program includes at least 1 area health education center, and that each such center—

(A) is a public or private organization whose structure, governance, and operation is independent from the awardee and the par-
tent institution of the awardee;

(B) is a school of medicine or osteo-
pathic medicine, the parent institution of such a school, or a branch campus or other subunit of a school of medicine or osteo-
pathic medicine or its parent institution, or a consortium of such entities;

(C) designates an underserved area or pop-
ulation to be served by the center which is in

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the geographic area or population served by the area health education center funded under this section.

(1) AUTHORIZATION OF APPROPRIATIONS.—There is hereby authorized to be appropriated to carry out this section $125,000,000 for each of the fiscal years 2010 through 2014.

(2) REQUIREMENTS.—Of the amounts ap-
propriated for a fiscal year under paragraph (1)—

(A) not more than 35 percent shall be used for awards under subsection (a)(1); and

(B) not less than 60 percent shall be used for awards under subsection (a)(2);
Section 4405. Primary Care Extension Program

Part P of title III of the Public Health Service Act (42 U.S.C. 286g et seq.), as amended by section 4113, is further amended by adding at the end the following:

"Sect. 399W. Primary Care Extension Program

(a) Establishment, purpose and definition.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a Primary Care Extension Program.

(2) PURPOSE.—The Primary Care Extension Program shall provide support and assistance to eligible entities to develop and implement activities to improve the accessibility, quality, and efficiency of primary care services, including health homes;

(3) Definitions.—In this section:

(1) HEALTH EXTENSION AGENCY.—The term 'Health Extension Agency' means any local, community-based health worker who facilitates and provides assistance to primary care practices by implementing quality improvement practices to share care of the patient-centered medical home to provide high-quality, effective, efficient, and safe primary care and to provide guidance to patients culturally and linguistically appropriate ways, and linking practices to diverse health system resources.

(2) PRIMARY CARE PROVIDER.—The term 'primary care provider' means a clinician who provides integrated, accessible health care services and who is accountable for addressing the large majority of personal health care needs, including preventive and health promotion services for men, women, and children of all ages, developing a sustained partnership with patients, and practicing in the context of family and community, as recognized by a State licensing or regulatory authority, unless otherwise specified in this section.

(b) Grants to Establish State Hubs and Local Primary Care Extension Agencies

(1) GRANTS.—Grants awarded under section 330G of the Public Health Service Act, as amended by section 4313, are further amended by adding at the end the following:

"(a) REQUIRED ACTIVITIES.—Primary Care Extension Agencies established by a Hub under paragraph (1) shall:

(i) assist primary care providers to implement the patient-centered medical home to improve the accessibility, quality, and efficiency of primary care services, including health homes;

(ii) develop and support primary care learning communities to enhance the dissemination of research findings for evidence-based practice, assess implementation of practice improvement, share best practices, and involve community clinicians in the generation of new knowledge and identification of important questions for research;

(iii) participate in the Network of Primary Care Extension Hubs and propose how the Primary Care Extension Agency will share and disseminate lessons learned and best practices; and

(iv) develop a plan for financial sustainability involving State, local, and private contributions, to provide for the reduction in Federal funds that is expected after an initial 6-year period of program establishment, infrastructure development, and planning.

(b) Discretionary Activities.—Primary Care Extension Agencies established by a Hub under paragraph (1) may—

(i) provide technical assistance, training, and organizational support for community health centers, local health departments, or other community agencies to develop and sustain patient-centered medical home infrastructure development, and planning.

(ii) collect data, and provide resources of primary care provider feedback from standardized measurements of processes and outcomes to aid in continuous performance improvement;

(iii) collaborate with local health department, community health centers, tribes and tribal entities, and other community agencies to identify and support the implementation of community-based efforts to address the social and primary determinants of health, strengthen the local primary care workforce, and eliminate health disparities.

(2) Applications.—To be eligible for a grant under subsection (b), a State or multistate entity shall submit an application, at such time, in such manner, and containing such information as the Secretary may require.

(c) State and local activities.—

(1) ELIGIBLE ENTITIES.—For purposes of this section, the term 'eligible entity' means any local, community-based provider that—

(a) makes grants to, and enter into contracts with, eligible entities to improve health care, training, and collaboration among faculty; the recruitment of minority faculty members, enhance the practice environment, and provide information dissemination and educational support to reduce professional isolation through the timely dissemination of research findings using relevant resources;

(b) ELIGIBLE ENTITIES.—For purposes of this section, the term 'eligible entity' means any local, community-based provider that—

(A) makes grants to, and enter into contracts with, eligible entities to improve health care, training, and collaboration among faculty; the recruitment of minority faculty members, enhance the practice environment, and provide information dissemination and educational support to reduce professional isolation through the timely dissemination of research findings using relevant resources;

(B) PRIMARY CARE PROVIDER.—The term 'primary care provider' means a clinician who provides integrated, accessible health care services and who is accountable for addressing the large majority of personal health care needs, including preventive and health promotion services for men, women, and children of all ages, developing a sustained partnership with patients, and practicing in the context of family and community, as recognized by a State licensing or regulatory authority, unless otherwise specified in this section.

(c) USE OF FUNDS.—An eligible entity shall use amounts awarded under a grant or contract under this section to provide innovative supportive activities to enhance education through distance learning, continuing educational activities, collaborative conferences, and electronic and telelearning activities, with priority for primary care and primary care providers to identify community health priorities and local health workforce needs, and participate in community-based efforts to address the social and primary determinants of health, strengthen the local primary care workforce, and eliminate health disparities;

(d) GRANTS TO ESTABLISH STATE HUBS AND LOCAL PRIMARY CARE EXTENSION AGENCIES.

(1) GRANTS.—The Secretary shall award competitive grants for the establishment of State- or multistate-level primary care Primary Care Extension Program State Hubs (referred to in this section as 'Hubs').

(2) COMPOSITION OF HUBS.—A Hub established by a State pursuant to paragraph (1) shall—

(A) consist of, at a minimum, the State health department and the departments of 1 or more health professions schools in the State that train providers in primary care; and

(B) may include entities such as hospital associations, primary care practice-based research networks, health professional societies, State primary care associations, State licensing boards, organizations with a community health home; or who participate in the Network of Primary Care Extension Agencies established by a Hub under paragraph (1) may—

(i) provide technical assistance, training, and organizational support for community health centers, local health departments, or other community agencies to develop and sustain patient-centered medical home infrastructure development, and planning.

(ii) collect data, and provide resources of primary care provider feedback from standardized measurements of processes and outcomes to aid in continuous performance improvement;

(iii) collaborate with local health department, community health centers, tribes and tribal entities, and other community agencies to identify and support the implementation of community-based efforts to address the social and primary determinants of health, strengthen the local primary care workforce, and eliminate health disparities.

(d) FEDERAL PROGRAM ADMINISTRATION.—

(1) GRANTS; TYPES.—Grants awarded under subsection (b) shall:

(A) Program grants, that are awarded to State or multistate entities that submit fully-developed plans for the implementation of a Hub, for a period of 6 years; or

(B) planning grants, that are awarded to State or multistate entities with the goal of developing a plan for a Hub, for a period of 2 years.

(2) APPLICATIONS.—To be eligible for a grant under subsection (b), a State or multistate entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(3) EVALUATION.—A State that receives a grant under subsection (b) shall submit to the Secretary an evaluation at the end of the grant period by an evaluation panel appointed by the Secretary.
“(4) CONTINUING SUPPORT.—After the sixth year in which assistance is provided to a State under a grant awarded under subsection (b), the State may receive additional support under this section. Funds awarded pursuant to this section shall not be used for funding direct patient care.

(e) REQUIREMENTS ON THE SECRETARY.—In carrying out this section, the Secretary shall consult with the heads of other Federal agencies with demonstrated experience and expertise in managing public health programs, such as the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, the National Institutes of Health, the Office of the National Coordinator for Health Information Technology, the Indian Health Service, the Cooperative Extension Service of the Department of Agriculture, and other entities, as the Secretary determines appropriate.

(f) DETERMINATION OF APPROPRIATIONS.—To awards grants as provided in subsection (d), there are authorized to be appropriated $120,000,000 for each of fiscal years 2011 and 2012, as may be necessary to carry out this section for each of fiscal years 2013 through 2014.

Subtitle F—Strengthening Primary Care and Other Improvements

SEC. 4501. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.

(a) DEMONSTRATION PROJECTS TO PROVIDE LOW-INCOME WORKFORCE NEEDS RECRUITMENT OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

(1) AUTHORITY TO CONDUCT DEMONSTRATION PROJECTS.—Title XX of the Social Security Act (42 U.S.C. 1001) is amended by adding at the end the following:

SEC. 2008. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.

(a) DEMONSTRATION PROJECTS TO PROVIDE LOW-INCOME WORKFORCE NEEDS RECRUITMENT OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

(1) AUTHORITY TO CONDUCT DEMONSTRATION PROJECTS.—Title XX of the Social Security Act (42 U.S.C. 1001) is amended by adding at the end the following:

(2) REQUIREMENTS.—

(A) AID AND SUPPORTIVE SERVICES.—In general.—A demonstration project conducted by an eligible entity awarded a grant under this section shall, if appropriate, provide eligible individuals participating in the project with financial aid, child care, case management, and other supportive services.

(ii) TREATMENT.—Any aid, services, or incentives provided to an eligible individual participating in a demonstration project under this section shall not be considered income, and shall not be taken into account for purposes of determining the individual’s eligibility for, or amount of, benefits under any means-tested program.

(B) CONSULTATION AND COORDINATION.—An eligible entity awarded a grant pursuant to this section shall demonstrate in the application that the entity has consulted with the State agency responsible for administering the State TANF program, the local workforce investment board in the area in which the project is conducted (unless the applicant is such board), the State workforce investment board established under section 111 of the Workforce Investment Act of 1998, and the State agency recognized under the Act of August 16, 1937 (commonly known as the ‘National Apprenticeship Act’) (or if no agency has been recognized in the State, the Secretary of the Department of Labor) and that the project will be carried out in coordination with such entities.

(3) DEMONSTRATION PROJECTS TO PROVIDE LOW-INCOME WORKFORCE NEEDS RECRUITMENT OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

(a) AUTHORITY TO AWARD GRANTS.—The Secretary may award grants as provided in subsection (c) to eligible entities that are States to conduct demonstration projects for purposes of developing core training competencies and certification programs for personal or home care aides. The Secretary shall—

(i) evaluate the efficacy of the core training competencies described in paragraph (3)(A) for newly hired personal or home care aides and the methods used by States to implement such competencies in accordance with the issues specified in paragraph (3)(B); and

(ii) ensure that the number of hours of training provided by States to implement demonstration projects with respect to such core training competencies are not less than the number of hours of training required under any applicable State or Federal law or regulation.

(4) DURATION.—A demonstration project shall be conducted under this subsection for not less than 3 years.

(c) CORE TRAINING COMPETENCIES FOR PERSONAL OR HOME CARE AIDES.—

(A) IN GENERAL.—The core training competencies for personal or home care aides described in this subparagraph include competencies with respect to the following areas:

(i) The role of the personal or home care aide (including differences between a personal or home care aide employed by an agency and a personal or home care aide employed directly by the health care consumer or an independent provider).

(ii) Consumer rights, ethics, and confidentiality (including the role of proxy decision makers in the case where a health care consumer has impaired decision-making capacity).

(iii) Communication, cultural and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills.

(iv) Personal care skills.

(v) Health care support.

(vi) Nutritional support.

(vii) Infection control.

(viii) Safety and emergency training.

(ix) Training specified in an individual consumer’s needs (including older individuals, younger individuals with disabilities, individuals with developmental disabilities, individuals with dementia, and individuals with mental and behavioral health needs).

(x) Self-Care.

(B) IMPLEMENTATION.—The implementation purposes specified in this subparagraph include the following:

(i) The length of the training.

(ii) The appropriate trainer to student ratio.

(iii) The amount of instruction time spent in the classroom as compared to on-site in the home or a facility.

(iv) Trainer qualifications.

(v) Content for a ‘hands-on’ and written certification exam.
(vi) Continuing education requirements.

(7) APPLICATION AND SELECTION CRITERIA.—

(A) IN GENERAL.—

(B) EXTENSION OF FAMILY-TO-FAMILY TRAINING GRANTS.—

(i) A community based, ambulatory pa-

(ii) operates a primary care residency pro-

(b) REDUCING THE NUMBER OF HOURS OF TRAIN-

(C) SELECTOR CRITERIA.—In selecting States to participate in the program, the Secretary shall establish criteria to ensure (if applicable with respect to the activities involved—

(C) STATE.—The term ‘State’ has the meaning given that term for purposes of title XIX.

(D) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States in developing written materials and protocols for such core training competencies.

(E) FUNDING.—

(1) IN GENERAL.—Subject to paragraph (2), out of any funds in the ‘Treasury not other-

(2) TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL OR HOME CARE AIDS.—With respect to the demonstration projects under subsection (b), the Secretary shall use $5,000,000 of the amount appropriated under paragraph (1) for each of fiscal years 2010 through 2014.

(3) EVALUATION AND REPORT.—

(A) ELIGIBLE ENTITY.—The term ‘eligible entity’ means an organization capable of providing technical assistance including an area health education center program as de-

(4) EVALUATION AND REPORT.—

(A) ELIGIBLE ENTITY.—The term ‘eligible entity’ means an organization capable of providing technical assistance including an area health education center program as de-

(b) PRIMARY CARE RESIDENCY PROGRAM.—

The term ‘primary care residency program’ means an approved graduate medical resi-

(c) APPLICATION.—A teaching health cen-

(D) nonAPPLICATION.—

(1) IN GENERAL.—Subject to paragraph (2), the preceding sections of this title shall not apply to grants awarded under this section.

(2) LIMITATIONS ON USE OF GRANTS.—Sec-

Section 206 of the Public Health Service Act (42 U.S.C. 293k et. seq.) is amended by inserting after section 206(c) further amended by inserting after section 749 the following:

(3) EXTENSION OF FAMILY-TO-FAMILY TRAIN-

(F) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term ‘eligible entity’ means an organization capable of providing technical assistance including an area health education center program as de-

(2) TECHNICAL ASSISTANCE PROVIDED BY AN ELIGIBLE ENTITY.—

(2) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to States in developing written materials and protocols for such core training competencies, including curricula developed to implement the project with respect to activities, as applicable, which may include consideration of such colleges as partners in such implementation.

(D) DEVELOPMENT OF TECHNICAL ASSIST-

(C) consultation and collaboration with community colleges regarding the development of curricula to implement the project; and

No funds appropriated under paragraph (1) shall be used to carry out demonstration projects under subsection (b) after fiscal year 2012.

(1) nonAPPLICATION.—

(1) REPORT ON INITIAL IMPLEMENTATION.—Not later than 1 year after the date of enactment of this section, the Secretary shall submit to Congress a report on the initial implementation of activities conducted under the demonstration project, including any available results of the evaluation conducted under subparagraph (A) with respect to such activities, together with such recom-

(2) final REPORT.—Not later than 1 year after the completion of the demonstration project, the Secretary shall submit to Con-

(3) on demonstrating the development of core training competencies, in-

Toward job satisfaction, mastery of job skills, beneficiary and family caregiver satisfaction with services, and additional measures determined by the Secretary in consultation with the expert panel; and

(2) LIMITATIONS ON USE OF GRANTS.—Sec-

Section 501(c)(1)(A)(i) of the Social Security Act (42 U.S.C. 1915(c)(1)(A)(i)) is amended by striking ‘‘fiscal year 2009’’ and inserting ‘‘each of fiscal years 2009 through 2012’’.

minimum number of hours should be re-

required.

(3) reports.—

(4) implementation.—

(4) APPLICATION AND ELIGIBILITY.—A State seeking to participate in the project shall—

(4) APPLICATION.—A State seeking to participate in the project shall—

(3) nonAPPLICATION.—

(1) nonAPPLICATION.—

(1) reports.—

(1) IN GENERAL.—The Secretary shall encourage participating States to consult with community and vocational colleges regarding the development of curricula to implement the project with respect to activities, as applicable, which may include consideration of such colleges as partners in such implementation.

(2) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to participating States regarding the development of curricula for such core training competencies, including curricula developed to implement the project; and

The Secretary shall encourage participating States to consult with community and vocational colleges regarding the development of curricula to implement the project with respect to activities, as applicable, which may include consideration of such colleges as partners in such implementation.
"(g) Authorization of Appropriations.—

There is authorized to be appropriated, $25,000,000 for fiscal year 2010, $50,000,000 for fiscal year 2011, $50,000,000 for fiscal year 2012, unless otherwise required by the Secretary of the Treasury, and may be necessary for each fiscal year thereafter to carry out this section. Not to exceed $5,000,000 annually may be used for technical assistance programs under this section.

(b) National Health Service Corps Teaching Capacity.—Section 338(a) of the Public Health Service Act (42 U.S.C. 254m(a)) is amended to read as follows:

"(a) Service in Full-Time Clinical Practice.—Except as provided in section 338b, each National Health Service Corps member who entered into a ten-year contract with the Secretary under section 338a or 338b shall provide service in the full-time clinical practice of such individual’s specialty for at least 75 percent of the time for the period of obligated service provided in such contract. For the purpose of calculating time spent in full-time clinical practice under this subsection, up to 50 percent of the time spent teaching by a member of the Corps may be counted toward his or her service obligation.

(c) Payments to Qualified Teaching Health Centers.—Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

"Subpart XX—Support of Graduate Medical Education in Qualified Teaching Health Centers

"SEC. 340A. PROGRAM OF PAYMENTS TO TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

"(a) Payments.—Subject to subsection (b)(2), the Secretary shall make payments under this section for direct expenses and for indirect expenses associated with the full-time clinical practice of Graduate Medical Education (GME) residents in order to ensure the direct and indirect expenses associated with the full-time clinical practice of such residents.

"(b) Amount of Payments.—

"(1) In General.—Subject to paragraph (2), the amounts payable under this section for direct expenses associated with the full-time clinical practice of such residents reported by a hospital in the application of the hospital for the current fiscal year shall be equal to an amount determined appropriate by the Secretary.

"(2) Factors.—In determining the amount payable under this section for direct expenses associated with the full-time clinical practice of such residents reported by a hospital in the application of the hospital for the current fiscal year, the Secretary shall—

"(A) determine the number of full-time equivalent residents reported by the hospital; and

"(B) divide the aggregate of the payments for indirect expenses associated with the additional costs of teaching residents for a fiscal year by the number of full-time equivalent residents reported by the hospital during the preceding fiscal year for the teaching health center’s area.

"(c) Amount of Payment for Indirect Expenses.—The amount determined under subsection (a) for direct graduate medical education for a fiscal year is equal to the product of—

"(A) the updated national per resident amount for direct graduate medical education, as determined under paragraph (2); and

"(B) the average number of full-time equivalent residents in the teaching health center’s graduate approved medical residency training programs as determined under subparagraph (F) of section 1886(h) of the Social Security Act (without regard to the limitation under subparagraph (F) of such section) during the fiscal year.

"(2) Updated National Per Resident Amount for Direct Graduate Medical Education.—The Secretary shall compute for each individual qualified teaching health center a per resident amount—

"(i) by dividing the national average per resident amount computed under section 340E(c)(2)(D) into a wage-related portion and a non-wage-related portion by applying the proportion determined under subparagraph (B);

"(ii) by multiplying the wage-related portion by the factor applied under section 1886(d)(3)(E) of the Social Security Act; and

"(iii) by adding the non-wage-related portion to the amount computed under clause (i).

"(3) Interim Payment.—Before the Secretary makes a payment under this subsection pursuant to a determination of indirect expenses under this section, the Secretary may provide to qualified teaching health centers a payment, in addition to any payment made under subsection (c), for indirect expenses associated with the additional costs of teaching residents for a fiscal year, based on an estimate by the Secretary.

"(d) Clarification Regarding Relationship to Other Payments for Graduate Medical Education.—Payments under this section—

"(1) shall be in addition to any payments—

"(A) for the indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act; and

"(B) for direct graduate medical education costs under section 1886(h) of such Act; and

"(2) shall not be taken into account in applying the limitation on the number of full-time equivalent residents in the teaching health center’s graduate approved medical residency training programs as determined under subparagraph (F) of section 1886(h) of such Act and clauses (v), (v)(I), and (v)(II) of section 1886(d)(5)(B) of such Act for the portion of a fiscal year that a resident rotates to a hospital; and

"(3) shall not include the time in which a resident is counted toward full-time equivalent residents living in underserved areas.

"(e) Reconciliation.—The Secretary shall determine any changes to the number of residents reported by a hospital in the application of the hospital for the current fiscal year to determine the amount payable to the hospital for the current fiscal year for both direct expense and indirect expense payments. Based on such determination, the Secretary shall recoup any overpayments made to pay any balance due to the extent possible. The final amount so determined shall be considered a final intermediary determination for the purposes of section 1878 of the Social Security Act and shall be subject to administrative review under that section in the same manner as the amount of payment under section 1186(d) of such Act is subject to review under such section.

"(f) Funding.—To carry out this section, there are appropriated such sums as may be necessary, not to exceed $230,000,000, for the period of fiscal years 2011 through 2013.

"(g) Annual Reporting Required.—

"(1) Annual Report.—The report required under this paragraph for a qualified teaching health center for a fiscal year is a report that includes (in a form and manner specified by the Secretary) the following information—

"(A) The types of primary care resident approved training programs that the qualified teaching health center provided for residents;

"(B) The number of approved training positions for residents described in paragraph (4).

"(2) Other Information as Required by the Secretary.

"(h) Audit Authority; Limitation on Payment.—

"(1) Audit Authority.—The Secretary may audit a qualified teaching health center to ensure the accuracy and completeness of the information submitted in a report under paragraph (1).

"(2) Limitation on Payment.—A teaching health center may only receive payment in a fiscal year if it reports to the Secretary that it meets the eligibility requirements determined by the Secretary for purposes of this paragraph, that it has completed the residency training at the end of such residency academic year, and for purposes of this subparagraph, the ‘base level of primary care residents’ for a teaching health center is the level of such residents as of a base period.

"(3) Reduction in Payment for Failure to Report.—

"(A) In General.—The amount payable under this section to a qualified teaching health center for a fiscal year shall be reduced by at least 25 percent if the Secretary determines that—

"(i) the qualified teaching health center has failed to provide the Secretary, in an amendment to the qualified teaching health center’s application under this section for such
fiscal year, the report required under paragraph (1) for the previous fiscal year;

(ii) such report fails to provide complete and accurate information required under any subparagraph of paragraph (1);

(b) Notice and opportunity to provide accurate and missing information.—Before imposing a reduction under subparagraph (a) on the basis of a qualified teaching health center's failure to provide complete and accurate information described in subparagraph (A)(ii), the Secretary shall provide notice—

(1) to the health center of such failure and the Secretary's intention to impose such reduction and shall provide the teaching health center with the opportunity to provide the required information within the period of 30 days beginning on the date of such notice. If the teaching health center provides such information within such period, no reduction shall be made under subparagraph (a) on the basis of the previous failure to provide such information.

(4) Residents.—The residents described in this paragraph are those who are in part-time or full-time equivalent resident training positions at a qualified teaching health center. A qualified teaching health center is a hospital that provides advanced practice registered nurses with qualified training.

(B) Limitation.—With respect to a year, the amount reimbursed under subparagraph (A) may not exceed the amount of costs described in subparagraph (A) that are attributable to providing advanced practice registered nurses enrolled in a program that provides qualified training during the year and for which the hospital is reimbur sable under the demonstration, as compared to the average number of advanced practice registered nurses who graduated in each year during the period beginning on December 31, 2010 (as determined by the Secretary) from the graduate nursing education program operated by the applicable school of nursing that is operating the hospital for purposes of the demonstration.

(c) Waiver authority.—The Secretary may waive such requirements of title XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration.

(6) Administration.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this section.

(7) Qualified training.—The term "qualified training" means training described in subparagraph (A) and includes formal postgraduate training programs in geriatric medicine approved by the American Geriatrics Society and the American College of Physicians and, at a minimum—

(A) participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the American Geriatrics Society and the American College of Physicians;

(B) that meets criteria for accreditation (as established by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the American Dental Association);

(C) approved graduate medical residency program.

The term "primary care residency program" has the meaning given that term in section 749A.

(3) Qualified teaching health center.—The term "qualified teaching health center" means a teaching health center in any approved graduate medical residency training program.

(a) In general.—The Secretary shall promulgate regulations to carry out this section.

(b) Definitions.—In this section:

(1) Approved graduate medical residency training program.—The term "approved graduate medical residency training program" means a residency or other postgraduate medical training program.

(2) Costs described.—(A) may not exceed the amount of costs described in subparagraph (2) for the provision of qualified training; and

(B) that meets criteria for accreditation (as established by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the American Dental Association).

(3) Demonstration.—The term "demonstration" means the graduate nurse education demonstration established under subsection (a).

(1) Eligible hospital.—The term "eligible hospital" means a hospital (as defined in section 1861 of the Social Security Act) which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration. Such settings include qualified health centers, rural health clinics, and other non-hospital settings as determined appropriate by the Secretary.

(2) Other terms.—The other terms used in this section and not defined in this paragraph have the meaning given such terms in section 749A.

(B) Waiver of requirement half of training to be provided in non-hospital community-based care setting.—The Secretary may waive the requirement under subparagraph (A)(ii) with respect to eligible hospitals located in rural or medically underserved areas.

(1) General.—The term "Secretary" means the Secretary of Health and Human Services.

Subtitle G—Improving Access to Health Care Services

SEC. 4601. SPENDING FOR FEDERA LLY QUALIFIED HEALTH CENTERS (FQHCs).

(a) In general.—(1) Amount appropriated for fiscal year 2016.—(A) For fiscal year 2016, $4,990,553,440.

(B) For fiscal year 2015, $8,332,924,155.

(C) For fiscal year 2014, $5,448,713,907.

(D) For fiscal year 2013, $3,332,924,145.

(E) For fiscal year 2012, $1,490,353,440.

(F) For fiscal year 2011, $3,382,102,470.

(G) For fiscal year 2010, $3,268,821,592.

(b) Amounts appropriated for fiscal year 2016.—(B) Waiver of requirement half of training to be provided in non-hospital community-based care setting in certain areas.—The Secretary may waive the requirement under subparagraph (A)(ii) with respect to eligible hospitals located in rural or medically underserved areas.

(1) General.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $50,000,000 for each of fiscal years 2012 through 2015 to carry out this section, including the design, implementation, monitoring, and evaluation of the demonstration.

(2) Proration.—If the aggregate payments to eligible hospitals under the demonstration exceed $50,000,000 for a fiscal year described in subparagraph (1), the Secretary shall prorate the payment amounts to each eligible hospital in order to ensure that the aggregate payments do not exceed such amount.

(3) Without fiscal year limitation.—Amounts appropriated under this subsection shall remain available without fiscal year limitation.

(4) Definitions.—In this chapter:

(a) Advanced practice registered nurse.—The term "advanced practice registered nurse" includes the following:

(A) A clinical nurse specialist (as defined in subsection (a)(5) of section 1861 of the Social Security Act (42 U.S.C. 1395x(u))).

(B) A nurse practitioner (as defined in such subsection).

(C) A certified registered nurse anesthetist (as defined in section 1861 of the Social Security Act (42 U.S.C. 1395x(v))) of each eligible hospital for the clinical training costs (as determined by the Secretary) that are attributable to providing advanced practice registered nurses with qualified training.

(b) Limitation.—With respect to a year, the amount reimbursed under subparagraph (A) may not exceed the amount of costs described in subparagraph (A) that are attributable to providing advanced practice registered nurses enrolled in a program that provides qualified training during the year and for which the hospital is reimbursable under the demonstration, as compared to the average number of advanced practice registered nurses who graduated in each year during the period beginning on December 31, 2010 (as determined by the Secretary) from the graduate nursing education program operated by the applicable school of nursing that is operating the hospital for purposes of the demonstration.

(c) Waiver authority.—The Secretary may waive such requirements of title XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration.

(6) Administration.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this section.

(7) Qualified training.—The term "qualified training" means training described in subparagraph (A) and includes formal postgraduate training programs in geriatric medicine approved by the American Geriatrics Society and the American College of Physicians and, at a minimum—

(A) participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the American Geriatrics Society and the American College of Physicians;

(B) that meets criteria for accreditation (as established by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the American Dental Association).

(3) Demonstration.—The term "demonstration" means the graduate nurse education demonstration established under subsection (a).

(5) Eligible hospital.—The term "eligible hospital" means a hospital (as defined in section 1861 of the Social Security Act (42 U.S.C. 1395x(v))) of each eligible hospital for the clinical training costs (as determined by the Secretary) from the graduate nursing education program operated by the applicable school of nursing that is operating the hospital for purposes of the demonstration.

(1) Written agreements with eligible partners.—No payment shall be made under this section to an eligible hospital unless such hospital is in written agreement with the eligible partners of the hospital. Such written agreement shall describe, at a minimum—

(1) the obligations of the eligible partners with respect to the provision of qualified training; and

(2) the obligation of the eligible hospital to reimburse such eligible partners applicable (in a timely manner) for the costs of such qualified training attributable to partner.

(c) Evaluation.—Not later than October 17, 2017, the Secretary shall submit to Congress a report on the demonstration. Such report shall include an analysis of the following:

(1) The growth in the number of advanced practice registered nurses with respect to a specific base year as a result of the demonstration.

(2) The growth for each of the specialties described in subparagraphs (A) through (D) of subsection (c)(1).

(3) Other items the Secretary determines appropriate and relevant.

(d) Funding.—

(1) In general.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $50,000,000 for each of fiscal years 2012 through 2015 to carry out this section, including the design, implementation, monitoring, and evaluation of the demonstration.

(2) Proration.—If the aggregate payments to eligible hospitals under the demonstration exceed $50,000,000 for a fiscal year described in subparagraph (1), the Secretary shall prorate the payment amounts to each eligible hospital in order to ensure that the aggregate payments do not exceed such amount.

(3) Without fiscal year limitation.—Amounts appropriated under this subsection shall remain available without fiscal year limitation.

(4) Definitions.—In this section:

(a) Advanced practice registered nurse.—The term "advanced practice registered nurse" includes the following:

(A) A clinical nurse specialist (as defined in subsection (a)(5) of section 1861 of the Social Security Act (42 U.S.C. 1395x(u))).

(B) A nurse practitioner (as defined in such subsection).

(C) A certified registered nurse anesthetist (as defined in subsection (bb)(2) of such section).

(D) A certified nurse-midwife (as defined in subsection (gg)(2) of such section).
“(t) one plus the average percentage increase in costs incurred per patient served; and

(ii) one plus the average percentage increase in the total number of patients served;”.

(b) RULE OF CONSTRUCTION.—Section 330(c) of the Public Health Service Act (42 U.S.C. 254d) is amended by adding at the end the following:

“(4) RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINIC FUNDING.—Nothing in this section shall be construed to prevent a community health center from contracting with a Federally certified rural health clinic (as defined in section 1861(aa)(2) of the Social Security Act), a low-volume hospital (as defined for purposes of section 1886 of such Act), a critical access hospital, or a sole community hospital (as defined for purposes of section 1861(d)(5)(D)(ii) of such Act) for the delivery of primary health care services that are available at the clinic or hospital for individuals who would otherwise be eligible for free or reduced cost care if that individual were able to obtain that care at the community health center.

Such services may be limited in scope to those primary health care services available in that clinic or hospitals.

“(B) ASSURANCES.—In order for a clinic or hospital to receive funding under this subsection through a contract with a community health center under subparagraph (A), such clinic or hospital shall establish policies to ensure—

(i) the ability to accommodate the clinical needs of primary care providers, including community health centers, to provide services to special populations, an eligible entity shall use funds awarded under this section for—

(A) the provision, by qualified primary care professionals, of on-site primary care services;

(B) reasonable costs associated with medically necessary referrals to qualified specialty care professionals, other coordination of care or, if permissible under the grant or cooperative agreement, by qualified specialty care professionals on a reasonable cost basis on site at the eligible entity;

(C) information technology required to accommodate the clinical needs of primary and specialty care professionals; or

(D) facility modifications needed to bring primary and specialty care professionals on site at the eligible entity.

(2) LIMITATION.—Not to exceed 15 percent of grant or cooperative agreement funds may be used for activities described in subparagraphs (C) and (D) of paragraph (1).

(3) EVALUATION.—Not later than 90 days after a grant or cooperative agreement awarded under this section expires, an eligible entity shall submit to the Secretary the results of an evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under the grant or agreement.

(A) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2014.”.

SEC. 4605. AWARD TO CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

(a) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term ‘‘eligible entity’’ means a qualified community mental health program defined under section 1913(b)(1).

(2) SPECIAL POPULATIONS.—The term ‘‘special populations’’ means adults with mental illnesses and persons who have co-occurring primary care conditions and chronic diseases.

(b) PROGRAM AUTHORIZED.—The Secretary, acting through the administrative authority established pursuant to section 1913(b)(1), shall award grants and cooperative agreements to establish demonstration projects for the provision of co-located primary and specialty care to special populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings.

(c) APPLICATION.—To be eligible to receive a grant or cooperative agreement under this section, an eligible entity shall submit an application to the Administrator at such time, in such manner, and accompanied by such information as the Administrator may require, for a demonstration project to establish and maintain a program to provide co-located primary and specialty care to special populations.

(d) USE OF FUNDS.—

(1) IN GENERAL.—For the benefit of special populations, an eligible entity shall use funds awarded under this section for—

(A) the provision by qualified primary care professionals, of on-site primary care services;

(B) the provision by qualified specialty care professionals, of on-site specialty care services; and

(C) the provision by qualified mental health professionals, of on-site mental health services.

(2) LIMITATION.—Not to exceed 15 percent of grant or cooperative agreement funds may be used for activities described in subparagraphs (B) and (C) of paragraph (1).

(3) EVALUATION.—Not later than 90 days after a grant or cooperative agreement awarded under this section expires, an eligible entity shall submit to the Secretary the results of an evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under the grant or agreement.

(A) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2014.”.

SEC. 5206. AWARDS FOR CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

(a) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term ‘‘eligible entity’’ means a qualified community mental health program defined under section 1913(b)(1).

(2) SPECIAL POPULATIONS.—The term ‘‘special populations’’ means adults with mental illnesses and persons who have co-occurring primary care conditions and chronic diseases.

(b) PROGRAM AUTHORIZED.—The Secretary, acting through the administrative authority under section 1913(b)(1), shall award grants and cooperative agreements to establish demonstration projects for the provision of co-located primary and specialty care to special populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings.

(c) APPLICATION.—To be eligible to receive a grant or cooperative agreement under this section, an eligible entity shall submit an application to the Administrator at such time, in such manner, and accompanied by such information as the Administrator may require, for a demonstration project to establish and maintain a program to provide co-located primary and specialty care to special populations.

(d) USE OF FUNDS.—

(1) IN GENERAL.—For the benefit of special populations, an eligible entity shall use funds awarded under this section for—

(A) the provision by qualified primary care professionals, of on-site primary care services;

(B) the provision by qualified specialty care professionals, of on-site specialty care services;

(C) the provision by qualified mental health professionals, of on-site mental health services; and

(D) the provision by qualified social work professionals, of on-site social work services.

(2) LIMITATION.—Not to exceed 15 percent of grant or cooperative agreement funds may be used for activities described in subparagraphs (B), (C), and (D) of paragraph (1).

(3) EVALUATION.—Not later than 90 days after a grant or cooperative agreement awarded under this section expires, an eligible entity shall submit to the Secretary the results of an evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under the grant or agreement.

(A) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2014.”.

SEC. 4606. KEY NATIONAL INDICATORS.

(a) DEFINITIONS.—In this section:

(1) ACADEMY.—The term ‘‘Academy’’ means the National Academy of Sciences.

(2) COMMISSION.—The term ‘‘Commission’’ means the Commission on Key National Indicators established and maintained under section (c)(3).

(3) INSTITUTE.—The term ‘‘Institute’’ means a Key National Indicators Institute as designated under subsection (c)(5).

(b) COMMISSION ON KEY NATIONAL INDICATORS.—

(1) ESTABLISHMENT.—There is established a Commission on Key National Indicators.

(A) NUMBER AND APPOINTMENT.—The Commission shall be composed of 8 members, to
shall last only for the remainder of that manner as the original appointment and Commission but shall be filled in the same manner as any inquiries by the Institute or designates an independent nonprofit organization as present appointment to implement a key national indicator system; and (iii) if the Academy designates an independent nonprofit organization as present appointment, it shall provide scientific and technical advice to the Institute and create an appropriate governance mechanism that balances Academy involvement and the independence of the Institute; and (iv) provide an annual report to the Com- mission addressing scientific and technical issues related to the key national indicator system and, if established, the Institute, and governance of the Institute’s budget and operations.

(b) PARTICIPATION.—In executing the arrange- ment under subparagraph (A), the National Academy of Sciences shall convene a multi-sector, multi-disciplinary process to define major scientific and technical issues associated with developing, maintaining, and evolving a Key National Indicator System and, if an Institute is established, to provide it with scientific and technical advice.

(c) ESTABLISHMENT OF A KEY NATIONAL INDICATOR SYSTEM.— (1) IN GENERAL.—In executing the arrange- ment under subparagraph (A), the National Academy of Sciences shall establish a key national indicator system by— (I) creating its own institutional capa- bility; or (II) partnering with an independent private nonprofit organization as an Institute to implement a key national indicator system.

(ii) determine how best to establish a key national indicator system for the United States, by either creating its own institutional capability or designating an independent nonprofit organization as present appointment to create a database allowing public access to the key national indicators.

(ii) Developing a quality assurance frame- work to ensure rigorous and independent procedures concerning potential issue areas and key indicators to be included in the Key National Indicators.

(1) GAO PROGRAMMATIC REVIEW.—The Comptroller General of the United States shall conduct programmatic assessments of the Institute established under this section as determined necessary by the Comptroller General and report the findings to the Commit- tee and the appropriate authorizing committees of Congress.

(iii) IDENTIFYING.—Identifying and selecting measures used for key national indicators within the issue areas under subclause (I).

(VI) Developing a budget for the construc- tion and management of a sustainable, adaptable, and evolving key national indicator system that reflects all Commission funding of Academy and, if an Institute is est- ablished, Institute activities.

(VII) Identifying and selecting data to pop- ulate the key national indicators described under subclause (II).

(VIII) Responding directly to the Commis- sion regarding its selection of issue areas, key indicators, data, and progress toward es- tablishing a web-accessible database.

(V) MODIFICATION AND CHANGES.—The Academy shall retain the sole discretion, at any time, to alter its approach to the establish- ment of a key national indicator system or, if an Institute is designated under clause (i)(II), to alter any aspect of its relationship with the Institute or to designate a different non-profit entity to serve as the Institute.

(b) GOVERNMENT ACCOUNTABILITY OFFICE STUDY AND REPORT.— (1) GAO STUDY.—The Comptroller General of the United States shall conduct a study of previous work conducted by all public agen- cies, private organizations, or foreign coun- tries with respect to best practices for a key national indicator system. The study shall be submitted to the appropriate authorizing committees of Congress.

(b) GOVERNMENT ACCOUNTABILITY OFFICE STUDY AND REPORT.— (1) GAO STUDY.—The Comptroller General of the United States shall conduct a study of previous work conducted by all public agen- cies, private organizations, or foreign coun- tries with respect to best practices for a key national indicator system. The study shall be submitted to the appropriate authorizing committees of Congress.

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(b) GOVERNMENT ACCOUNTABILITY OFFICE STUDY AND REPORT.— (1) GAO STUDY.—The Comptroller General of the United States shall conduct a study of previous work conducted by all public agen- cies, private organizations, or foreign coun- countries with respect to best practices for a key national indicator system. The study shall be submitted to the appropriate authorizing committees of Congress.
SEC. 1128F. TRANSPARENCY REPORTS AND RE¬
serting after section 1128F the following new
act (42 U.S.C. 1301 et seq.) is amended by in-
cluding after section 1128F the following new
section:
SEC. 1128G. TRANSPARENCY REPORTS AND RE¬
"(a) Transparency Reports.—
"(1) Payments or other transfers of value.—
"(A) In general.—On March 31, 2013, and
on the 90th day of each calendar year begin¬
ing thereafter, any applicable manufacturer that provides a payment or other transfer of value to a covered recipient (or to an entity or individual at the request of or designated on behalf of a covered recipient), shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:
"(i) The name of the covered recipient.
"(ii) The business address of the covered recipient and, in the case of a covered recipient who is a physician, the specialty and National Provider Identifier of the covered recipient.
"(iii) The amount of the payment or other transfer of value.
"(iv) The dates on which the payment or other transfer of value was provided to the covered recipient.
"(v) A description of the form of the payment or other transfer of value, indicated (as appropriate for all that apply) as—
"(I) cash or a cash equivalent;
"(II) in-kind items or services;
"(III) a stock option, or any other ownership interest, dividend, profit, or other return on investment; or
"(IV) any other form of payment or other transfer of value (as defined by the Secretary).
"(vi) A description of the nature of the payment or other transfer of value, indicated (as appropriate for all that apply) as—
"(I) consulting fees;
"(II) compensation for services other than consulting;
"(III) Honoraria;
"(IV) gift;
"(V) entertainment;
"(VI) food;
"(VII) travel (including the specified destinations);
"(VIII) education;
"(IX) research;
"(X) charitable contribution;
"(XI) royalty or license;
"(XII) current or prospective ownership or investment interest;
"(XIII) direct or indirect compensation for serving as faculty or as a speaker for a medical education program;
"(XIV) grant; or
"(XV) any other nature of the payment or other transfer of value (as defined by the Secretary).
"(vii) If the payment or other transfer of value is in payment or other transfer of value specific to a covered drug, device, biological, or medical supply, the name of that covered drug, device, biological, or medical supply.
"(viii) Any other categories of information regarding the payment or other transfer of value the Secretary determines appropriate.
"(b) Form of the report.—The Secretary, in consultation with the applicable manufacturer or applicable group purchasing organization, shall provide for the definition of terms (other than those terms defined in subsection (a)), and appropriate, for purposes of section 1128F(a)(1), except that in applying such clauses, ‘physician’ shall be substituted for ‘covered recipient’ each place it appears.
"(C) Any payment or other transfer of value provided to a physician holding such an ownership or investment interest (or to a business entity or person at the request of or designated on behalf of a physician holding such an ownership or investment interest), including the information described in clauses (i) through (vii) of paragraph (1)(A), except that in applying such clauses, ‘physician’ shall be substituted for ‘covered recipient’ each place it appears.
"(D) Any other information regarding the ownership or investment interest the Secretary determines appropriate.
"(E) Penalties for noncompliance.—
"(1) Failure to report.—
"(A) In general.—Subject to subparagraph (B) except as provided in paragraph (2), any applicable manufacturer or applicable group purchasing organization that fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, including any penalties imposed under such subsection, shall be subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties imposed under section 1128A are imposed and collected under such section.
"(B) Knowledge failure to report.—
"(A) In general.—Subject to subparagraph (B), any applicable manufacturer or applicable group purchasing organization that knowingly fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties imposed under section 1128A are imposed and collected under such section.
"(B) Limitation.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $100,000.
"(C) Use of funds.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.
"(D) Procedures for submission of information and public availability.—
"(1) In general.—
"(A) Establishment.—Not later than October 1, 2011, the Secretary shall establish procedures—
"(i) for applicable manufacturers and applicable group purchasing organizations to submit information to the Secretary under subsection (a); and
"(ii) for the Secretary to make such information submitted available to the public.
"(B) Payment or transfer of value.—The procedures established under subparagraph (A) shall provide for the definition of terms (other than those terms defined in subsection (e)), and appropriate, for purposes of section 1128F(a)(1), except as provided in subparagraph (E).
"(C) Public availability.—Except as provided in subparagraph (E), the procedures established under subsection (a) shall ensure that, not later than September 30, 2013, and on June 30 of each calendar year beginning thereafter, the information submitted under subsection (a) with respect to the preceding calendar year is made available through an Internet website that—
"(i) is searchable and is in a format that is clear and understandable;
"(ii) contains information that is presented by the name of the applicable manufacturer or applicable group purchasing organization, the name of the covered recipient, the business address of the covered recipient, the specialty of the covered recipient, the value of the payment or other transfer of value, the date on which the payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(V), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(VI), the name of the covered drug, device, biological, or medical supply, as applicable;
"(iii) contains information that is able to be easily aggregated and downloaded;
"(iv) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year;
"(v) contains background information on industry-physician relationships;
"(vi) in the case of information submitted with respect to a payment or other transfer of value described in subparagraph (E), lists such information separately from the other information submitted under subsection (a) and designates such separately listed information as funding for clinical research;
"(vii) contains any other information the Secretary determines would be helpful to the average consumer;
"(viii) does not contain the National Provider Identifier of the covered recipient, and
"(ix) only includes information with respect to the applicable manufacturer, applicable group purchasing organization, or covered recipient an opportunity to review and submit with respect to the information submitted with respect to the applicable manufacturer, applicable group purchasing organization, or covered recipient, respectively, for errors or corrections to the information being made available to the public.
"(D) Clarification of time period for review and corrections.—In no case may the 45-day period for review and submission of corrections to information under subparagraph (A) of this subsection be subject to an appeal or other transfer of value described in subsection (e)(1)(E)(i), such information shall be included in the first report submitted to States after the date on which such information is made available to the public under such subsection.

(19) Relation to State Laws.—

(A) In general.—In the case of a payment or other transfer of value provided by an applicable manufacturer that is received by a covered recipient (as defined in section 1877(h)(2)) on or after January 1, 2012, subject to subparagraph (B), the provisions of this section shall not preempt any statute or regulation of a State that requires the disclosure or reporting of information—

(i) not of the type required to be disclosed or reported under this section;

(ii) described in subparagraph (e)(10)(B), except in the case of information described in clause (i) of such subparagraph;

(iii) by any person or entity other than an applicable manufacturer (as so defined) or a covered recipient (as defined in section (e)); or

(iv) to a Federal, State, or local government agency for public health surveillance, investigation, or other public health purposes or health oversight purposes.

(B) Nothing in subparagraph (A) shall be construed to limit the discovery or admissibility of information described in such subparagraph in a criminal, civil, or administrative proceeding.

(C) Consultation.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services on the implementation of this section.

(D) Definitions.—In this section:

(i) A transfer of anything the value of which is less than $10, unless the aggregate amount transferred, requested by, or desired on behalf of the covered recipient by the applicable manufacturer during the calendar year exceeds $100. For calendar years after 2012, the dollar amounts specified in the preceding sentence shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) for the 12-month period ending with June of the previous year.

(ii) Product samples that are not intended to be sold and are intended for patient use.

(iii) Provisional materials that directly benefit patients or are intended for patient use.

(iv) The loan of a covered device for a shorter trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

(v) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

(vi) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

(vii) Discounts, rebates, credits, or other transfers of value.

(viii) In-kind items used for the provision of charity care.

(ix) A dividend or other profit distribution that is not intended to be an ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

(x) In the case of an applicable manufacturer, offers a self-insured plan, pay- ments for the provision of health care to employees under the plan.

(xi) In the case of a covered recipient who is a licensed non-medical professional, a transfer of anything of value to the covered recipient if the transfer is payment solely for

(A) A teaching hospital.

(B) Exclusion.—Such term does not include a physician who is an employee of the applicable manufacturer that is required to submit information under this section.

(7) Employer.—The term ‘employee’ has the meaning given such term in section 3301(a).

(8) Manufacturer of a covered drug, device, biological, or medical supply.—The term ‘manufacturer’ of a covered drug, device, biological, or medical supply includes any entity which is engaged in the production, preparation, propagation, compounding, dispensing, or distribution of a covered drug, device, biological, or medical supply (or any entity under common ownership with such entity which provides assistance or support to such entity with respect to the production, preparation, propagation, compounding, conversion, marketing, promotion, sale, or distribution of a covered drug, device, biological, or medical supply).

(9) Payment or other transfer of value.—

(A) In general.—The term ‘payment or other transfer of value’ means a transfer of anything of value. Such term does not include a transfer of anything of value that is indirectly transferred through a third party in connection with an activity or service in the case where the applicable manufacturer is unaware of the identity of the covered recipient.

(B) Exclusions.—An applicable manufacturer shall not be required to submit information under subsection (a) with respect to the following:

(i) A transfer of anything of value which is less than $10, unless the aggregate amount transferred, requested by, or desired on behalf of the covered recipient by the applicable manufacturer during the calendar year exceeds $100. For calendar years after 2012, the dollar amounts specified in the preceding sentence shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) for the 12-month period ending with June of the previous year.

(ii) Product samples that are not intended to be sold and are intended for patient use.

(iii) Provisional materials that directly benefit patients or are intended for patient use.

(iv) The loan of a covered device for a shorter trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

(v) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

(vi) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

(vii) Discounts, rebates, credits, or other transfers of value.

(viii) In-kind items used for the provision of charity care.

(ix) A dividend or other profit distribution that is not intended to be an ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

(x) In the case of an applicable manufacturer, offers a self-insured plan, pay- ments for the provision of health care to employees under the plan.

(xi) In the case of a covered recipient who is a licensed non-medical professional, a transfer of anything of value to the covered recipient if the transfer is payment solely for

(A) A teaching hospital.
the non-medical professional services of such licensed non-medical professional.

"(xii) In the case of a covered recipient who is a physician, a transfer of anything of value to the covered recipient if the transfer is payment solely for the services of the covered recipient with respect to a civil or criminal action or an administrative proceeding.

"(11) PHYSICIAN.—The term ‘physician’ has the meaning given that term in section 1861(r).

SEC. 5002. PRESCRIPTION DRUG SAMPLE TRANSPARENCY.

Part A of title XI of the Social Security Act (42 U.S.C. 1390 et seq.), as amended by section 5001, is amended by inserting after section 1128G the following new section:

"SEC. 1128H. REPORTING OF INFORMATION RELATING TO DRUG SAMPLES.

"(a) IN GENERAL.—Not later than April 1 of each year (beginning with 2012), each manufacturer and authorized distributor of record of an applicable drug shall submit to the Secretary (in a form and manner specified by the Secretary) the following information with respect to the preceding year:

"(1) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

"(2) any other category of information determined appropriate by the Secretary.

"(b) Definitions.—In this section:

"(1) APPLICABLE DRUG.—The term ‘applicable drug’ means a drug—

"(A) which is subject to subsection (b) of such section 503; and

"(B) for which payment is available under a State health security program.

"(2) INFORMATION DESCRIBED.—

"(A) IN GENERAL.—The following information is described in subparagraph (1), (2), or (3) of such subsection:

"(i) The information described in subparagraphs (a) and (b), subject to subparagraph (C).

"(ii) The identity of and information on—

"(I) each member of the governing body of the facility, including the name, title, and period of service of such person or entity; and

"(III) each person or entity who is an additional disclosable party of the facility.

"(iii) The organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

"(B) SPECIAL RULE WHERE INFORMATION IS ALREADY REPORTED OR SUBMITTED.—To the extent that information contained in a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, information submitted by the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the facility may provide such Form or such information submitted to meet the requirements of paragraph (1).

"(C) SPECIAL RULE.—In applying subparagraph (A)(i) with respect to subsections (a) and (b), ‘ownership or control interest’ shall include directly or indirectly interests, including such interests in intermediate entities; and

"(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured, in whole or in part, by the entity or any part of the property or assets thereof, if the interest is equal to or exceeds 5 percent of the total property or assets of the entity.

"(D) ORGANIZATIONAL STRUCTURE.—The term ‘organizational structure’ means, in the case of—

"(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent; and

"(ii) a limited liability company, the members and managers of the limited liability company (including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company);

"(iii) a general partnership, the partners of the general partnership;

"(iv) a limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent; and

"(D) MANAGING EMPLOYEE.—The term ‘managing employee’ means, with respect to a facility, an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

PART I—IMPROVING TRANSPARENCY OF INFORMATION

SEC. 501. REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.

"(1) DISCLOSURE.—A facility shall have the information described in paragraph (2) available—

"(A) during the period beginning on the date of the enactment of this subsection and ending on the later of the date on which such final regulations are published in the Federal Register or the date on which the Secretary promulgates final regulations requiring, effective on the date that is 90 days after the date on which such final regulations are published, a facility to report the information described in paragraph (2) to the Secretary in a standardized format, and such other regulations as are necessary to carry out this subsection. Such final regulations shall ensure that the facility certifies, as a condition of participation and payment under a State health security program, that the information reported by the facility in accordance with such final regulations is, to the best of the facility’s knowledge, accurate and current.

"(B) beginning on the date of the enactment of this subsection, that the information reported by the facility in accordance with such final regulations is, to the best of the facility’s knowledge, accurate and current.

"(2) INFORMATION FOR REPORTING.—Nothing in this subsection shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

"(3) DEFINITIONS.—In this subsection:

"(A) ADDITIONAL DISCLOSABLE PARTY.—The term ‘additional disclosable party’ means, with respect to a facility, any person or entity who—

"(iv) a limited partnership, the general partners and any limited partners of the limited liability company who have an ownership interest in the limited liability company;

"(v) a trust, the trustees of the trust;

"(vi) an individual, contact information for the individual; and

"(D) ADDITIONAL DISCLOSABLE PARTY.—The term ‘additional disclosable party’ means, with respect to a facility, any person or entity who—

"(ii) a nursing facility (as defined in section 1819(a));

"(C) ADDITIONAL DISCLOSABLE PARTY.—The term ‘additional disclosable party’ means, with respect to a facility, any person or entity who—

"(iv) a limited partnership, the general partners and any limited partners of the limited liability company who have an ownership interest in the limited liability company;
SEC. 5102. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES AND NURSING FACILITIES.

Part A of title XI of the Social Security Act (42 U.S.C. 1315 et seq.), as amended by section 4009 of division A of the Bipartisan Budget Act of 2015 (Public Law 114-74) and the Patient Protection and Affordable Care Act of 2010, is amended by inserting after section 1129A the following new section:

SEC. 1128I. ACCOUNTABILITY REQUIREMENTS FOR FACILITIES.

(a) Definition of Facility.—In this section, the term 'facility' means—

(1) a skilled nursing facility (as defined in section 1919(a)); or

(2) a nursing facility (as defined in section 1919(a)).

(b) Effective Compliance and Ethics Programs.—

(1) Requirement.—On or after the date that is 2 years after the date of the enactment of this Act, the Secretary, working jointly with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program developed under paragraph (2).

(2) Design of Regulations.—Such regulations with respect to specific elements or formality of a program shall, in the case of an organization that operates 5 or more facilities, vary with the size of the organization, such that larger organizations should have a more formal program and include established processes for identifying deficiencies and changes in such regulations and procedures to be followed by the employees. Such requirements may specifically apply to the corporate level management of multi unit nursing home chains.

(c) Evaluation.—Not later than 3 years after the date of the promulgation of regulations under this paragraph, the Secretary shall establish a plan for the implementation of such compliance and ethics programs required to be established under this subsection. Such evaluation shall determine if such programs led to changes, deficiencies, citations, changes in quality performance, or changes in other metrics of patient quality of care. The Secretary shall submit to Congress a report on such evaluation, which shall include the Secretary’s recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

SEC. 5104. STAFFING ACCOUNTABILITY.

Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

SEC. 1128J. STAFFING ACCOUNTABILITY.

(a) Definition of Facility.—In this section, the term 'facility' includes—

(1) a skilled nursing facility (as defined in section 1919(a)); or

(2) a nursing facility (as defined in section 1919(a)).

(b) Effective Compliance and Ethics Programs.—

(1) Requirement.—On or after the date that is 2 years after the date of the enactment of this Act, the Secretary shall establish a plan for the implementation of such compliance and ethics programs required to be established under this subsection. Such evaluation shall determine if such programs led to changes, deficiencies, citations, changes in quality performance, or changes in other metrics of patient quality of care. The Secretary shall submit to Congress a report on such evaluation, which shall include the Secretary’s recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

SEC. 5105. STAFFING ACCOUNTABILITY.

Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

SEC. 1128K. STAFFING ACCOUNTABILITY.

(a) Definition of Facility.—In this section, the term 'facility' includes—

(1) a skilled nursing facility (as defined in section 1919(a)); or

(2) a nursing facility (as defined in section 1919(a)).

(b) Effective Compliance and Ethics Programs.—

(1) Requirement.—On or after the date that is 2 years after the date of the enactment of this Act, the Secretary shall establish a plan for the implementation of such compliance and ethics programs required to be established under this subsection. Such evaluation shall determine if such programs led to changes, deficiencies, citations, changes in quality performance, or changes in other metrics of patient quality of care. The Secretary shall submit to Congress a report on such evaluation, which shall include the Secretary’s recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.
verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

(1) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

(2) include resident census data and information on resident case mix;

(3) include a regular reporting schedule; and

(4) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in paragraph (1) per resident per day.

Nothing in this subsection shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employ- ees. Nothing in this subsection with respect to agency and contract staff shall be kept separate from information on employee staffing.

PART II—TARGETING ENFORCEMENT

SEC. 5111. CIVIL MONEY PENALTIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395i–3(h)(2)(B)(ii)) is amended—

(A) by striking ''PENALTIES.—The Secretary'' and inserting ''PENALTIES.—The Secretary''; and

(B) by adding at the end the following new subclauses:

(II) REDUCTION OF CIVIL MONEY PENALTIES

(1) IN GENERAL.—Section 1819(h)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1395i–3(h)(3)(C)(ii)) is amended—

(A) by striking ''(ii)'',''’’(iv)'',''’’(vi)'',''’’(vii)'',''’’(viii)'' and inserting ''(ii)'' after ''(i)''.;

(B) by adding at the end the following new subclauses:

(III) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

(aa) GENERAL.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(IV) COLLECTION OF CIVIL MONEY PENALTIES—

(aa) GENERAL.—If a civil money penalty is imposed under this clause, the Secretary shall issue regulations that—

(1) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

(bb) in the case where the penalty is imposed for noncompliance with respect to a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

(ff) in the case where such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (volun- tarily or involuntarily) or is decertified (in- cluding offsetting costs of relocating resi- dents to home and community-based settings or another facility), projects that support support activities that benefit residents, in- cluding offsetting costs of relocating resi- dents to home and community-based settings or another facility, or projects that support residents and family councils and other con- sumer involvement in assuring quality care in facilities, and facility improvement initia- tives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities imple- menting quality assurance programs, the ap- pointment of temporary management firms, and other activities approved by the Sec- retary).

(II) CERTAIN OTHER DEFICIENCIES.

(aa) GENERAL.—The Secretary may reduce the amount of a penalty imposed on the facility for any subsequent year under such subclause (II) if the penalty is imposed for each day of noncompliance provided for in such program, group, or party.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Subject to subclause (II), the Secretary; and

(2) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

(aa) GENERAL.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(cc) REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty has been imposed on the facility in the preceding year for such subclause with respect to a repeat deficiency.

(dd) MAJOR DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty has been imposed on the facility in the preceding year for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(2) CONFORMING AMENDMENT.—The second sentence of section 1819(h)(5) of the Social Security Act (42 U.S.C. 1395i–3(h)(5)) is amended by inserting ''(ii)(IV),'' after ''(i)''.

(b) NURSES.—

(1) IN GENERAL.—Section 1919(h)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(3)(C)(ii)) is amended—

(A) by striking ''(ii)'',''’’(iv)'',''’’(vi)'',''’’(vii)'',''’’(viii)'' and inserting ''(ii)'' after ''(i)''.;

(2) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 5112. NATIONAL INDEPENDENT MONITOR DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a demonstration project to develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facili- ties and nursing facilities.

(2) SELECTION.—The Secretary shall select chains of skilled nursing facilities and nurs- ing facilities described in paragraph (1) to participate in the demonstration project under this section from among those chains that submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary requires.

(b) REQUIREMENTS.—The Secretary shall evaluate chains selected to participate in the demonstration project under this section based on criteria selected by the Secretary, including whether evidence suggests that a number of the facilities of the chain are ex- periencing serious safety and quality of care problems. Such criteria may include the evaluation of a chain that includes a number of facilities participating in the 'Special
Focus Facility program (or a successor program) or multiple facilities with a record of repeated serious safety and quality of care deficiencies;

(c) RESPONSIBILITIES.—An independent monitor that enters into a contract with the Secretary to participate in the conduct of the demonstration project under this section shall—

(1) conduct periodic reviews and prepare root-cause quality and deficiency analyses of a chain, the facilities of the chain are in compliance with State and Federal laws and regulations applicable to the facilities;

(2) conduct sustained oversight of the efforts of the Secretary to participate in, whether publicly or privately held, to achieve compliance by facilities of the chain with State and Federal laws and regulations applicable to the facilities;

(3) analyze the management structure, distribution of expenditures, and nurse staffing levels of facilities of the chain in relation to resident census, staff turnover rates, and tenure;

(4) report findings and recommendations with respect to such reviews, analyses, and oversight to the chain and facilities of the chain, to the Secretary, and to relevant States; and

(5) publish the results of such reviews, analyses, and oversight.

(d) IMPLEMENTATION OF RECOMMENDATIONS.—

(1) REPORT OF FINDINGS BY CHAIN.—Not later than 10 days after receipt of a finding of an independent monitor under subsection (c)(4)(A), a chain participating in the demonstration project shall submit to the independent monitor a report—

(A) outlining corrective actions the chain will take to implement the recommendations of the independent monitor; and

(B) indicating that the chain will not implement such recommendations, and why it will not do so.

(2) RECEIPT OF REPORT BY INDEPENDENT MONITOR.—Not later than 10 days after receipt of a report submitted by a chain under paragraph (1), an independent monitor shall finalize its recommendations and submit a report to the chain and facilities of the chain, the Secretary, and the State or States, as appropriate, containing such final recommendations.

(e) COST OF APPOINTMENT.—A chain shall be responsible for a portion of the costs associated with the appointment of independent monitors under the demonstration project under this section. The chain shall pay such portion to the Secretary (in an amount and in accordance with procedures established by the Secretary).

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

(g) DEFINITIONS.—In this section:

(1) ADDITIONAL DISCLOSABLE PARTY.—The term ‘‘additional disclosable party’’ has the meaning given such term in section 1124(c)(5)(A) of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

(2) in the second sentence, by striking ‘‘the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program shall be established on a permanent basis; and

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

SEC. 5113. NOTIFICATION OF FACILITY CLOSURE.

(a) IN GENERAL.—Section 1128 of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

(1) in the second sentence, by striking ‘‘the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program shall be established on a permanent basis; and

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

(b) CONFORMING AMENDMENTS.—Section 1819(h)(4) of the Social Security Act (42 U.S.C. 1395i–3(h)(4)) is amended—

(1) in the first sentence, by striking ‘‘the Secretary shall take no administrative action’’ and inserting ‘‘the Secretary, subject to section 1128(h), shall terminate’’; and

(2) in the second sentence, by striking ‘‘subsection (c)(2)’’ and inserting ‘‘subsection (c)(2) and section 1123(h)’’.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 5114. NATIONAL DEMONSTRATION PROJECTS ON CULTURE CHANGE AND USE OF INFORMATION TECHNOLOGY IN NURSING HOMES.

(a) IN GENERAL.—The Secretary shall conduct 2 demonstration projects, 1 for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement (including the development of resources for facilities to find and access funding in order to undertake culture change) and 1 for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care.

(b) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) GRANT AWARD.—Under each demonstration project conducted under this section, the Secretary shall award 1 or more grants to facility-based settings for the development of best practices described in subsection (a) with respect to the demonstration project involved. Such award shall be made on a competitive basis and may be allocated in 1 lump-sum payment.

(2) CONSIDERATION OF SPECIAL NEEDS OF RESIDENTS.—Each demonstration project conducted under this section shall take into consideration the special needs of residents of skilled nursing facilities and nursing facilities who have cognitive impairment, including dementia.

(3) DURATION AND IMPLEMENTATION.—

(1) DURATION.—The demonstration projects shall each be conducted for a period not to exceed 3 years.

(2) IMPLEMENTATION.—The demonstration projects shall each be implemented not later than 1 year after the date of the enactment of this Act.

(3) COMPARATIVE STUDY.—

(a) IN GENERAL.—The demonstration projects shall each be conducted in 2 settings, 1 setting using an approach as the Secretary determines appropriate.

(b) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Section 1819(f)(2)(A)(i)(I) is amended by inserting ‘‘in the second sentence, by striking ‘‘the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program shall be established on a permanent basis; and

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

PART III—IMPROVING STAFF TRAINING

SEC. 5121. DEMENTIA AND ABUSE PREVENTION TRAINING.

(a) SKILLED NURSING FACILITIES.—


(2) in the first sentence, by striking ‘‘the Secretary shall take no administrative action’’ and inserting ‘‘the Secretary, subject to section 1128(h), shall terminate’’; and

(3) in the second sentence, by striking ‘‘subsection (c)(2)’’ and inserting ‘‘subsection (c)(2) and section 1123(h)’’.

(4) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

(5) COMPARATIVE STUDY.—

(a) IN GENERAL.—The demonstration projects shall each be conducted in 2 settings, 1 setting using an approach as the Secretary determines appropriate.

(b) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Section 1819(f)(2)(A)(I)(I) is amended by inserting ‘‘in the second sentence, by striking ‘‘the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program shall be established on a permanent basis; and

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

(2) in the second sentence, by striking ‘‘the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program shall be established on a permanent basis; and

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

(3) in the second sentence, by striking ‘‘the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program shall be established on a permanent basis; and

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

(4) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

(5) COMPARATIVE STUDY.—

(a) IN GENERAL.—The demonstration projects shall each be conducted in 2 settings, 1 setting using an approach as the Secretary determines appropriate.

(b) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Section 1819(h)(2)(A)(I)(I) is amended by inserting ‘‘in the second sentence, by striking ‘‘the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program shall be established on a permanent basis; and

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

(2) in the second sentence, by striking ‘‘the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program shall be established on a permanent basis; and

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

(3) in the second sentence, by striking ‘‘the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program shall be established on a permanent basis; and

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

(4) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

(5) COMPARATIVE STUDY.—

(a) IN GENERAL.—The demonstration projects shall each be conducted in 2 settings, 1 setting using an approach as the Secretary determines appropriate.

(b) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Section 1819(h)(2)(A)(I)(I) is amended by inserting ‘‘in the second sentence, by striking ‘‘the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program shall be established on a permanent basis; and

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

(2) in the second sentence, by striking ‘‘the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program shall be established on a permanent basis; and

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

(3) in the second sentence, by striking ‘‘the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program shall be established on a permanent basis; and

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.
case of ongoing training, dementia management training, and patient abuse prevention training’’ before ‘‘(ii)’’.
(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1396r(f)(2)(A)(I)) is amended by inserting ‘‘(including, in the case of initial training and, if appropriate, renewal training, in the case of ongoing training, dementia management training, and patient abuse prevention training’’ before ‘‘(ii)’’.
(b) NURSING FACILITIES.—
(1) IN GENERAL.—Section 1919(b)(2)(A)(I) of the Social Security Act (42 U.S.C. 1396r(f)(2)(A)(I)) is amended by inserting ‘‘including, in the case of initial training and, if appropriate, renewal training, in the case of ongoing training, dementia management training, and patient abuse prevention training’’ before ‘‘(ii)’’.
(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1396r(f)(2)(A)(I)) is amended by inserting ‘‘including, in the case of initial training and, if appropriate, renewal training, in the case of ongoing training, dementia management training, and patient abuse prevention training’’ before ‘‘(ii)’’.
(c) THE PROVISION OF BACKGROUND CHECKS ON PROSPECTIVE EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.
SEC. 5201. NATIONWIDE PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.
(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ‘‘Secretary’’) shall establish a program to identify efficient, effective, and economic procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the ‘‘nationwide program’’). Except for the following modifications, the Secretary shall carry out the nationwide program under similar conditions as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 150; the prohibition on using waiving workers and the authorization of the imposition of penalties by a participating State under subsection (b)(3)(A) and (b)(6) of such section shall be referred to as the ‘‘nationwide program’’). For the purposes of the nationwide program, the Secretary shall—
(i) submit an application to the Secretary containing such information and at such time as the Secretary may specify.
(ii) agree to conduct background checks under the program established under subsection (a) of such section 307 on a Statewide basis; and
(iii) submit an application to the Secretary containing such information and at such time as the Secretary may specify.
(b) NONAPPLICATION OF SELECTION CRITERIA.—Subsection (b)(3)(B) of such section 307 shall not apply.
(c) REQUIRED BACKGROUND CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.
The procedures established under subsection (b)(1) of such section 307 shall—
(A) require that the long-term care facility or provider (as defined in subsection (c)(3)(B)) conduct a criminal history background check, if appropriate, for each direct patient access employee of a long-term care facility or provider, using such means as the Secretary determines appropriate, efficient, and effective that will allow the Secretary to identify efficient, effective, and economic procedures for long term care facilities
(B) require States to develop and implement the procedures described in paragraph (A) as part of any background check conducted with respect to such employee, except that in no case may the payment contributed, as a condition of receiving the Federal match under clause (ii).
(c) THE PROVISION OF BACKGROUND CHECKS ON PROSPECTIVE EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.
(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(A)(iii), the Secretary shall agree to conduct background checks under the program in accordance with the requirements of this subsection.
(ii) MONITOR COMPLIANCE.—The procedures established under this paragraph shall be in effect, and the Secretary shall monitor compliance with the procedures under this paragraph and require States to maintain records relating to such compliance.
(iii) REQUIREMENT FOR MONITORING.—The procedures established under this paragraph shall be carried out by the Secretary and the Secretary shall require States to maintain records relating to such compliance.
(iv) PROVIDE FOR THE DESIGNATION OF A SINGLE STATE AGENCY AS RESPONSIBLE FOR—
(I) overseeing the coordination of any State national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such records;
(II) overseeing the design of appropriate privacy and security safeguards for use in the review of the results of any State or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;
(III) immediately reporting to the long-term care facility or provider that requested the criminal history background check the results of such review; and
(IV) in the case of an employee with a conviction for a relevant crime, that is subject to reporting under section 1128E of the Social Security Act (42 U.S.C. 1320a–7e), reporting the existence of such conviction to the database established under that section.
(v) DETERMINE WHICH INDIVIDUALS ARE DIRECT PATIENT ACCESS EMPLOYEES.—Subsection (b)(6) of such section 307 shall be as follows:
(A) AS APPLICABLE, SPECIFY OFFENSES, INCLUDING CONVICTIONS FOR VIOLENT CRIMES, FOR PURPOSES OF THE NATIONAL BACKGROUND CHECK PROGRAM, INCLUDING THE SPECIFICATION OF CRITERIA FOR APPEALS FOR DIRECT PATIENT ACCESS EMPLOYEES.
(b) NONAPPLICATION OF SELECTION CRITERIA.—Subsection (b)(3)(B) of such section 307 shall not apply.
(c) REQUIRED BACKGROUND CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.
The procedures established under subsection (b)(1) of such section 307 shall—
(A) require that the long-term care facility or provider (as defined in subsection (c)(3)(B)) conduct a criminal history background check, if appropriate, for each direct patient access employee of a long-term care facility or provider, using such means as the Secretary determines appropriate, efficient, and effective that will allow the Secretary to identify efficient, effective, and economic procedures for long term care facilities
(B) require States to develop and implement the procedures described in paragraph (A) as part of any background check conducted with respect to such employee, except that in no case may the payment contributed, as a condition of receiving the Federal match under clause (ii).
(c) THE PROVISION OF BACKGROUND CHECKS ON PROSPECTIVE EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.
(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(A)(iii), the Secretary shall agree to conduct background checks under the program in accordance with the requirements of this subsection.
(ii) MONITOR COMPLIANCE.—The procedures established under this paragraph shall be in effect, and the Secretary shall monitor compliance with the procedures under this paragraph and require States to maintain records relating to such compliance.
(iii) REQUIREMENT FOR MONITORING.—The procedures established under this paragraph shall be carried out by the Secretary and the Secretary shall require States to maintain records relating to such compliance.
(iv) PROVIDE FOR THE DESIGNATION OF A SINGLE STATE AGENCY AS RESPONSIBLE FOR—
(I) overseeing the coordination of any State national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such records;
(II) overseeing the design of appropriate privacy and security safeguards for use in the review of the results of any State or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;
(III) immediately reporting to the long-term care facility or provider that requested the criminal history background check the results of such review; and
(IV) in the case of an employee with a conviction for a relevant crime, that is subject to reporting under section 1128E of the Social Security Act (42 U.S.C. 1320a–7e), reporting the existence of such conviction to the database established under that section.
(v) DETERMINE WHICH INDIVIDUALS ARE DIRECT PATIENT ACCESS EMPLOYEES.—Subsection (b)(6) of such section 307 shall be as follows:
(A) AS APPLICABLE, SPECIFY OFFENSES, INCLUDING CONVICTIONS FOR VIOLENT CRIMES, FOR PURPOSES OF THE NATIONAL BACKGROUND CHECK PROGRAM, INCLUDING THE SPECIFICATION OF CRITERIA FOR APPEALS FOR DIRECT PATIENT ACCESS EMPLOYEES.
(b) NONAPPLICATION OF SELECTION CRITERIA.—Subsection (b)(3)(B) of such section 307 shall not apply.
(c) REQUIRED BACKGROUND CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.
The procedures established under subsection (b)(1) of such section 307 shall—
(A) require that the long-term care facility or provider (as defined in subsection (c)(3)(B)) conduct a criminal history background check, if appropriate, for each direct patient access employee of a long-term care facility or provider, using such means as the Secretary determines appropriate, efficient, and effective that will allow the Secretary to identify efficient, effective, and economic procedures for long term care facilities
(B) require States to develop and implement the procedures described in paragraph (A) as part of any background check conducted with respect to such employee, except that in no case may the payment contributed, as a condition of receiving the Federal match under clause (ii).
(c) THE PROVISION OF BACKGROUND CHECKS ON PROSPECTIVE EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.
In general.—As part of the application submitted by a State under paragraph (1)(B)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in providing, under the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (i).

(ii) Federal match.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $1,500,000.

(6) Definitions.—Under the nationwide program:

(A) Conviction for a relevant crime.—The term ‘‘conviction for a relevant crime’’ means any Federal or State criminal conviction for—

(i) any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a-7); or

(ii) any other offense as a participating State may specify for purposes of conducting the program in such State.

(B) Disqualifying information.—The term ‘‘disqualifying information’’ means a conviction for a relevant crime or a finding of patient or resident abuse.

(C) Finding of patient or resident abuse.—The term ‘‘finding of patient or resident abuse’’ means a substantiated finding of an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

(ii) such other types of acts as a participating State may specify for purposes of conducting the program in such State.

(D) Direct patient access employee.—The term ‘‘direct patient access employee’’ means any individual who has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider and has duties that involve (or may involve) one-on-one contact with a patient or resident of the facility or provider, as determined by the Secretary of the Treasury of the amount necessary to carry out the nationwide program under this section for the period of fiscal years 2010 through 2012, except that in no case shall such amount exceed $160,000,000.

(2) Transfer of funds.—

(A) In general.—Out of any funds in the Treasury, the Secretary of the Treasury shall provide for the transfer to the Secretary of Health and Human Services of the amount specified as necessary to carry out the nationwide program under paragraph (1). Such amount shall remain available until expended.

(B) Reserves of funds for conduct of evaluation.—The Secretary may reserve not more than $3,000,000 of the amount transferred under subparagraph (A) for the conduct of the evaluation under subsection (a)(7).

SEC. 4. Definitions and certain provisions.

Def. Sec. 409 of the Social Security Act (42 U.S.C. 1395x(d)(1)(B)(vi))

(vi) any provider of personal care services.

(vii) a provider of adult day care.

(viii) an assisted living facility that provides a level of care established by the Secretary.

(ix) an intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act (42 U.S.C. 1396d(d))).

(2) Comparative clinical effectiveness research; research.—

(A) In general.—The terms ‘‘comparative clinical effectiveness research’’ and ‘‘research’’ in this section for purposes of the nationwide program and competition of health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items described in subsection (B).

(B) Medical treatments, services, and items described.—The medical treatments, services, and items described in this subparagraph are health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologicals), integrated health practices, and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals.

(3) Conflict of interest.—The term ‘‘conflict of interest’’ means an association, including a financial or personal association, that has the potential to bias or have the appearance of biasing an individual’s decisions in matters related to the Institute or the conduct of activities under this section.

(4) Application of provisions.—The term ‘‘real conflict of interest’’ means any instance where a member of the Board, the methodology committee established under subsection (d)(6), or an advisory panel appointed under subsection (d)(4), or a close relative of such member, has received or could receive either of the following:

(A) A direct financial benefit of any amount deriving from the result or findings of a study conducted under this section.

(B) A financial benefit from individuals or companies that own or manufacture the medical treatments, services, or items to be studied under this section that in the aggregate exceed $10,000 per year. For purposes of the preceding sentence, a financial benefit includes honoraria, fees, stock, or other financial benefit and the current value of the member or close relative’s already existing stock holdings, in addition to any direct financial benefit deriving from the results or findings of a study conducted under this section.

SEC. 5. Establishment of Institute.

Sec. 501. Patient-Centered Outcomes Research Institute.

Title XI of the Social Security Act (42 U.S.C. 1391 et seq.) is amended by adding at the end the following new part:

PART D—Comparative Clinical Effectiveness Research

‘‘Comparative clinical effectiveness research’’ means—

(1) the conduction of research performed under this section.

(2) the compilation and dissemination of findings of comparative clinical effectiveness research.

SEC. 1181. Definitions.—In this section—

(1) Board.—The term ‘‘Board’’ means the Board of Governors established under subsection (f).

(2) Comparative clinical effectiveness research; research.—

(A) In general.—The terms ‘‘comparative clinical effectiveness research’’ and ‘‘research’’ in this section for purposes of the nationwide program and competition of health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items described in subsection (B).

(3) Conflict of interest.—The term ‘‘conflict of interest’’ means an association, including a financial or personal association, that has the potential to bias or have the appearance of biasing an individual’s decisions in matters related to the Institute or the conduct of activities under this section.

(4) Application of provisions.—The term ‘‘real conflict of interest’’ means any instance where a member of the Board, the methodology committee established under subsection (d)(6), or an advisory panel appointed under subsection (d)(4), or a close relative of such member, has received or could receive either of the following:

(A) A direct financial benefit of any amount deriving from the result or findings of a study conducted under this section.

(B) A financial benefit from individuals or companies that own or manufacture the medical treatments, services, or items to be studied under this section that in the aggregate exceed $10,000 per year. For purposes of the preceding sentence, a financial benefit includes honoraria, fees, stock, or other financial benefit and the current value of the member or close relative’s already existing stock holdings, in addition to any direct financial benefit deriving from the results or findings of a study conducted under this section.

(C) Establishment of the Patient-Centered Outcomes Research Institute.—

(1) Establishment.—There is established a nonprofit corporation, to be known as the ‘‘Patient-Centered Outcomes Research Institute’’ (referred to in this section as the ‘‘Institute’’), which is an agency or establishment of the United States Government.

(2) Application of provisions.—The Institute shall be subject to the provisions of this section and, to the extent consistent with this section, to the District of Columbia Nonprofit Corporation Act.

(c) Purpose.—The purpose of the Institute is to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, appropriateness of the medical treatments, services, and items described in subsection (B).

(d) Duties.—

(1) Identifying research priorities and establishing research project agenda.—

(2) Comparing clinical effectiveness research; research.—

(A) In general.—The terms ‘‘comparative clinical effectiveness research’’ and ‘‘research’’ in this section for purposes of the nationwide program and competition of health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items described in subsection (B).

(B) Medical treatments, services, and items described.—The medical treatments, services, and items described in this subparagraph are health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologicals), integrated health practices, and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals.

(3) Conflict of interest.—The term ‘‘conflict of interest’’ means an association, including a financial or personal association, that has the potential to bias or have the appearance of biasing an individual’s decisions in matters related to the Institute or the conduct of activities under this section.

(4) Application of provisions.—The term ‘‘real conflict of interest’’ means any instance where a member of the Board, the methodology committee established under subsection (d)(6), or an advisory panel appointed under subsection (d)(4), or a close relative of such member, has received or could receive either of the following:

(A) A direct financial benefit of any amount deriving from the result or findings of a study conducted under this section.

(B) A financial benefit from individuals or companies that own or manufacture the medical treatments, services, or items to be studied under this section that in the aggregate exceed $10,000 per year. For purposes of the preceding sentence, a financial benefit includes honoraria, fees, stock, or other financial benefit and the current value of the member or close relative’s already existing stock holdings, in addition to any direct financial benefit deriving from the results or findings of a study conducted under this section.
"(A) IDENTIFYING RESEARCH PRIORITIES.—

The Institute shall identify national priorities for research, taking into account factors of disease incidence, prevalence, and burden in the United States (with emphasis on chronic conditions), gaps in evidence in terms of clinical outcomes, practice variations and health disparities in terms of delivery of care, the potential for new evidence to improve patient health, well-being, and the quality of care, the effect on national expenditures associated with a health care strategy, or outcomes of care, as well as patient needs, outcomes, and preferences, the relevance to patients and clinicians in making informed health care decisions, and priorities to develop the Strategic Framework for transforming health care delivery and outcomes of care, the potential for differences in the effectiveness of health care treatments, services, and items as used with various subpopulations, such as racial and ethnic minorities, women, age, and geographic areas with different comorbidities, genetic and molecular subtypes, or quality of life preferences and inclusion of members of such subpopulations as subjects in the research as feasible and appropriate.

"(B) CONTRACTS FOR THE MANAGEMENT OF FUNDING AND CONDUCT OF RESEARCH.—

"(1) CONTRACTS.—In accordance with the research project agenda established under paragraph (A), the Institute shall enter into contracts for the management of funding and conduct of research in accordance with the following:

"(aa) Appropriate agencies and instrumentality of the Federal Government.

"(bb) Appropriate academic research, private sector research, or study-conducting entities.

"(ii) PREFERENCE.—In entering into contracts under clause (i), the Institute shall give preference to the Agency for Healthcare Research and Quality and the National Institutes of Health, but only if the research to be conducted under such contract is authorized by the governing statutes of such Agency or Institutes.

"(ii) CONDITIONS FOR CONTRACTS.—A contract entered into under this subparagraph shall require that the agency, instrumentality, or other entity—

"(I) abide by the transparency and conflict of interest requirements under subsection (h) that apply to the Institute with respect to the research managed or conducted under such contract;

"(II) comply by the methodology standards adopted under paragraph (9) with respect to such research;

"(III) consult with the expert advisory panels for clinical trials and rare disease approved under paragraphs (1) and (iii), respectively, of paragraph (4)(A);

"(IV) permit, under paragraph (4)(D), permit a researcher who conducts original research under the contract for the agency, instrumentality, or other entity to have such research published in a peer-reviewed journal or other publication;

"(V) have appropriate processes in place to manage data privacy and meet ethical standards for research involving human subjects;

"(VI) comply with the requirements of the Institute for making the information available to the public under paragraph (8); and

"(VII) comply with other terms and conditions determined appropriate by the Institute to carry out the research agenda adopted under paragraph (2).

"(iii) COVERAGE OF COPAYMENTS OR COINSURANCE.—A contract entered into under this subparagraph may allow for the coverage of copayments or coinsurance, or allow for other appropriate measures, to the extent that such coverage or other measures are necessary to preserve the validity of a research project, such as in the case where the research project must be blinded.

"(iv) RESEARCH AND DESIGN FOR A SYSTEMATIC REVIEW OF EVIDENCE.—Any research published under clause (ii)(iv) shall be within the bounds of and consistent with the evidence and findings included under the contract with the Institute under this subparagraph.

If the Institute determines that those requirements are not met, the Institute shall not enter into another contract with the agency, instrumentality, or entity which managed or conducted such research for a period determined appropriate by the Institute (but not less than 5 years).

"(C) REVIEW AND UPDATE OF EVIDENCE.—

The Institute shall review and update evidence on a periodic basis as appropriate.

"(D) TAKING INTO ACCOUNT POTENTIAL DIFFERENCES.—Research shall be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care treatments, services, and items as used with various subpopulations, such as racial and ethnic minorities, women, age, and geographic areas with different comorbidities, genetic and molecular subtypes, or quality of life preferences and inclusion of members of such subpopulations as subjects in the research as feasible and appropriate.

"(E) DIFFERENCES IN TREATMENT MODALITIES.—Research shall be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care treatments, services, and items as used with various subpopulations, such as racial and ethnic minorities, women, age, and geographic areas with different comorbidities, genetic and molecular subtypes, or quality of life preferences and inclusion of members of such subpopulations as subjects in the research as feasible and appropriate.

"(F) DATA COLLECTION.—

"(A) IN GENERAL.—The Secretary shall, with appropriate safeguards for privacy, make available to the Institute such data collected by the Centers for Medicare & Medicaid Services, as well as provide access to the data and to such other data as the Institute and its contractors may require to carry out this section. The Institute may also request and obtain data from Federal, State, or private entities, including data from clinical databases and registries.

"(B) USE OF DATA.—The Institute shall only use data provided to the Institute under this subparagraph in accordance with laws and regulations governing the release and use of such data, including applicable confidentiality and privacy standards.

"(G) APPOINTING EXPERT ADVISORY PANELS.—

"(A) APPOINTMENT.—

"(I) IN GENERAL.—The Institute may appoint permanent or ad hoc expert advisory panels as determined appropriate to assist in identifying research priorities and establishing the research agenda under paragraph (1) and for other purposes.

"(II) EXPERT ADVISORY PANELS FOR CLINICAL TRIALS.—The Institute shall appoint expert advisory panels in accordance with the research project agenda under paragraph (2)(A)(ii). Such expert advisory panels shall advise the Institute, the agency, instrumentality, or entity conducting the research on the research question involved and the research design or priorities, including integrating subgroups and other elements of the research. Such panels shall be available as a resource for technical questions that may arise during the conduct of such research and with respect to

"(III) ADVISORY PANEL FOR RARE DISEASE.—In the case of a research study for rare disease, the Institute shall appoint an expert advisory panel for purposes of assisting in the design of the research study and determining the relevance and feasibility of conducting the research study.

"(III) COMPOSITION.—The expert advisory panel appointed under subparagraph (A) shall include representatives of practicing and research clinicians, patients, and others involved in the research, health services research, health delivery, and evidence-based medicine who have experience in the relevant topic, and as appropriate, experts in the field of health services research, clinical research, comparative clinical effectiveness research, biostatistics, genomics, and research methodologies. Stakeholders with expertise may be appointed to the methodology committee. In addition to the members appointed under the first sentence, the Directors of the National Institutes of Health and the Agency for Healthcare Research and Quality and their designees shall each be included as members of the methodological committee.

"(G) FUNCTION.—Subject to subparagraph (D), the methodology committee shall work to develop and improve the science and methods of comparative clinical effectiveness research by not later than 18 months after the establishment of the Institute, directly or through subcontract, developing and periodically updating the following:

"(I) Methodological standards for research. Such methodological standards shall provide specific criteria for internal validity, generalizability, feasibility, and timelines of research and for health outcomes, risk adjustment, and other relevant aspects of research and assessment with respect to
the design of research. Any methodological standards developed and updated under this subclause shall be scientifically based and include methods by which new information, data, and procedures and technology are considered and incorporated into ongoing research projects by the Institute, as appropriate. The process for developing and updating such standards shall be guided by input from relevant experts, stakeholders, and decisionmakers, and shall provide opportunities for public comment. Such standards shall also include mechanisms for patient subgroup data that can be accounted for and evaluated in different types of research. As appropriate, such standards shall be updated on an ongoing basis on methodological standards for defined categories of health interventions and for each of the major categories of comparative clinical effectiveness research methods (determined as of the date of enactment of the Patient Protection and Affordable Care Act).

(ii) A translation table that is designed to provide guidance and act as a reference for the Board to determine research methods that are most likely to address each specific research question.

(3) PROCUREMENT AND CONDUCT OF EXAMINATIONS.—The methodology committee may consult and contract with the Institute of Medicine of the National Academies and academic, nonprofit, or other private and governmental entities with relevant expertise to carry out activities described in subparagraph (C) and may consult with relevant stakeholders to perform research activities.

(4) REPORTS.—The methodology committee shall submit reports to the Board on the committee’s performance of the functions described in subparagraph (C). Reports shall contain recommendations for the Institute to adopt methodological standards developed and used by the methodology committee as well as other actions deemed necessary to comply with such methodological standards.

(7) PROVIDING FOR A PEER-REVIEW PROCESS FOR PRIMARY RESEARCH.—

(A) IN GENERAL.—The Institute shall ensure that there is a process for peer review of primary research described in subparagraph (A)(ii) of paragraph (2) that is conducted under such paragraph. Under such process—

(i) evidence from such primary research shall be peer-reviewed scientific and methodological standards and adopted under paragraph (9); and

(ii) any relevant information (including information on the membership of the Board, expert advisory panels, methodology committee, and the executive staff of the Institute, any conflicts of interest, and any bylaws adopted by the Board) shall be provided to relevant Institute activities in a manner that is comprehensible and useful to patients and providers in making health care decisions;

(iii) shall be reviewed to assess scientific integrity, including the role of such experts in the scientific field relevant to the research under review.

(C) USE OF EXISTING PROCESSES.—

(i) PEER-REVIEW PROCESS OF ANOTHER ENTITY.—In the case where the Institute enters into a contract or other arrangement with another entity for the conduct or management of research under this section, the Institute may utilize the peer-review process of such entity if such process meets the requirements under subparagraphs (A) and (B).

(ii) PROCESS OF APPROPRIATE MEDICAL JOURNALS.—The Institute may utilize the peer-review process of appropriate medical journals if such process meets the requirements under subparagraphs (A) and (B).

(8) RELEASE OF RESEARCH FINDINGS.—

(A) IN GENERAL.—The Institute shall, not later than 90 days after the conduct of or receipt by the Institute of such research findings, make such research findings available to clinicians, patients, and the general public.

The Institute shall ensure that the research findings—

(i) convey the findings of research in a manner that is comprehensible and useful to patients and providers in making health care decisions;

(ii) fully convey findings and discuss considerations specific to certain subpopulations, risk factors, and comorbidities, as appropriate;

(iii) include limitations of the research and what further research may be needed as appropriate to the use of data under this section.

(iv) be not construed as mandates for practice guidelines, coverage recommendations, payment, or policy recommendations;

and

(v) not include any data which would violate the privacy of research participants or any confidentiality agreements made with respect to the use of data under this section.

(9) ADJUDICATION.—Subject to subsection (h)(1), the Institute shall adopt the national priorities identified under paragraph (1)(A), the research project agenda established under paragraph (6)(C)(i), and any peer-review process provided under paragraph (5)(B).

In the case where the Institute does not adopt such processes in accordance with the preceding sentence, the processes shall be re-referred to the appropriate staff or entity within the Institute (or, in the case of the methodological standards, the methodology committee) for further review.

(10) ANNUAL REPORTS.—The Institute shall submit an annual report to Congress and the President, and shall make the annual report available to the public. Such report shall contain—

(A) a description of the activities conducted under this section, research priorities identified under paragraph (1)(A) and methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i) that are adopted under paragraphs (6)(C)(ii) and (6)(C)(iii) during the preceding year;

(B) the research project agenda and budget of the Institute for the following year;

(C) any administrative activities conducted by the Institute during the preceding year;

(D) the names of individuals contributing to any peer-review process conducted by the Institute during the preceding year or years that shall be made public and included in annual reports in accordance with paragraph (10)(D);

(E) any other relevant information (including information on the membership of the Board, expert advisory panels, methodology committee, and the executive staff of the Institute, any conflicts of interest, and any bylaws adopted by the Board) shall be provided to the public.

(11) ADMINISTRATION.—

(A) IN GENERAL.—Subject to paragraph (2), the Board shall carry out the duties of the Institute.

(B) NONDELEGABLE DUTIES.—The activities described in subsections (d)(1) and (d)(9) are nondelegable.

(12) BOARD OF GOVERNORS.—

(A) IN GENERAL.—The Institute shall have a Board of Governors, which shall consist of the following members:

(i) The Director of the Agency for Healthcare Research and Quality (or the Director’s designee).

(ii) The Director of the National Institutes of Health (or the Director’s designee).

(iii) The Assistant Secretary for Health (or the Secretary’s designee).

(iv) Fourteen members appointed, not later than 6 months after the date of enactment of this section, by the Comptroller General of the United States as follows:

(I) 3 members representing patients and health care consumers.

(II) 3 members representing physicians and providers, including at least 1 surgeon, nurse, State-licensed integrative health care practitioner, and representative of a hospital.

(III) 3 members representing pharmaceutical, chemical, device, and diagnostic manufacturers or developers.

(IV) 3 members representing quality improvement or independent health service researchers.

(B) The Director of the National Institutes of Health (or the Director’s designee) shall be a member representing the Federal Government or the States, including at least 1 member representing a Federal health program or agency.

(C) QUALIFICATIONS.—The Board shall represent a broad range of perspectives and collectively have scientific expertise in clinical health sciences research, including epidemiology, decisions sciences, health economics, and statistics. In appointing the Board, the Comptroller General of the United States shall consider and disclose any conflicts of interest in accordance with paragraph (h)(4)(B). Members of the Board shall be recused from relevant Institute activities in the case where the member (or an immediate family member) has or may have a real conflict of interest directly related to the research project or the matter that could affect or be affected by such participation.

(D) TERMS, VACANCIES, AND APPOINTMENT.—The term of service of a member of the Board shall be for a term of 6 years, except with respect to the members first appointed, whose terms of appointment shall be staggered evenly over 2-year increments. No individual shall be appointed to the Board for more than 2 terms. Vacancies shall be filled in the same manner as the original appointment was made.

(E) CHAIRPERSON AND VICE-CHAIRPERSON.—The Comptroller General of the United States shall designate a Chairperson and Vice Chairperson of the Board from among the members of the Board. Such members shall serve as Chairperson or Vice Chairperson for a period of 3 years.

(F) COMPENSATION.—Each member of the Board who is not an officer or employee of the Federal Government shall be entitled to compensation (equivalent to the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code) and expenses incurred while performing the duties of the Board. An officer or employee of the Federal Government who is a member of the Board shall be exempt from compensation.

(G) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—The Board may employ and fix the compensation of an Executive Director and such other personnel as necessary to carry out the duties of the Institute and may seek such assistance and support of, or contract with, experts and consultants that may be necessary for the performance of the duties of the Institute.

(7) MEETINGS AND HEARINGS.—The Board shall meet and hold hearings at the call of the Chairperson or a majority of its members. Meetings not solely concerning matters of personnel shall be advertised at least 7 days in advance and open to the public. A quorum of the Board members shall constitute a quorum, but a lesser number of members may meet and hold hearings.

(F) FINANCIAL AND GOVERNMENTAL OVERSIGHT.—

(A) CONTRACT FOR AUDIT.—The Institute shall provide for the conduct of financial audits of the Institute on an annual basis by a firm skilled with expertise in conducting financial audits.

(B) REVIEW AND ANNUAL REPORTS.—
(A) REVIEW.—The Comptroller General of the United States shall review the following:

(1) Not less frequently than on an annual basis, the financial audits conducted under paragraph (2);

(2) Not less frequently than every 5 years, the processes established by the Institute, including the research priorities and the conduct of research projects, in order to determine whether information produced by such research projects is objective and credible, is produced in a manner consistent with the requirements under this section, and is developed through a transparent process.

(B) ANNUAL REPORTS.—Not later than April 1 of each year, the Comptroller General of the United States shall publish in Congress a report containing the results of the review conducted under subparagraph (A) with respect to the preceding year (or years, if applicable), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(h) Ensuring Transparency, Credibility, and Access.—The Institute shall establish procedures to ensure that the following requirements for ensuring transparency, credibility, and access are met:

(1) Public Comment Periods.—The Institute shall provide for a public comment period of not less than 45 days and not more than 60 days prior to the adoption under subsection (d)(9) of the national priorities identified under subsection (d)(1)(A), the research project agenda established under subsection (d)(3)(B), the methodological standards developed and updated by the methodology committee under subsection (d)(6)(C)(i), and the peer-review process provided under paragraph (3), that consider the release of draft findings with respect to systematic reviews of existing research and evidence.

(2) Additional Forums.—The Institute shall provide for additional forums to increase public awareness and obtain and incorporate public input and feedback through media (such as an Internet website) on research priorities, research findings, and other duties, activities, or processes the Institute determines appropriate.

(3) Public Availability.—The Institute shall make available to the public and disclose through the official Internet website of the Institute the following:

(A) Information contained in research findings as specified in subsection (d)(9);

(B) The process and methods for the conduct of research, including the identity of the entity and the investigators conducting such research and conflicts of interest of such parties, any direct or indirect links the entity has to industry, and research protocols, including measures taken, methods of research and analysis, research results, and such other information the Institute determines appropriate) concurrent with the release of research findings.

(4) Notice of public comment periods under paragraph (1), including deadlines for public comments.

(D) Subsequent comments received during each of the public comment periods.

(E) In accordance with applicable laws and processes and as the Institute determines appropriate, proceedings of the Institute.

(5) Disclosure of Conflicts of Interest.—(A) In general.—A conflict of interest shall be disclosed in the following manner: 

(i) By the Institute in appointing members to an expert advisory panel under subsection (d)(4), in selecting individuals to contribute to publications produced under section (d)(7), and for employment as executive staff of the Institute.

(ii) By the Comptroller General in appointing members of the methodology committee under subsection (d)(6);

(iii) By the Institute in the annual report under section (d)(9) in that, in the case of individuals contributing to any such peer review process, such disclosure shall be in a manner such that those individuals cannot be identified with a particular research project.

(B) MANNER OF DISCLOSURE.—Conflicts of interest shall be disclosed as described in subparagraph (A) as soon as practicable on the Internet website of the Institute and of the Government Accountability Office. The information disclosed under the preceding sentence shall include the type, nature, and magnitude of the interests of the individual involved, except to the extent that the individual recuses himself or herself from participating in the consideration of or any other activity with respect to the study as to which the potential conflict exists.

(i) RULES.—The Institute, its Board or staff, shall be prohibited from accepting gifts, bequests, or donations of services or property. In addition, the Institute shall be prohibited from establishing a corporation or generating revenue from activities other than provided under this section.

Subtitle F—Elder Justice Act

SEC. 5401. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ‘Elder Justice Act of 2009’.

SEC. 5402. DEFINITIONS.

Except as otherwise specifically provided, any term that is defined in section 2011 of the Social Security Act (as added by section 5503(a)) and is used in this subtitle has the meaning given such term by such section.

SEC. 5405. ELDERS JUSTICE.

(a) ELDERS JUSTICE.—

(1) IN GENERAL.—Title XX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(A) in the heading, by inserting ‘AND ELDERS JUSTICE’ after ‘SOCIAL SERVICES’;

(B) by inserting before section 2001 the following:

‘Subtitle A—Block Grants to States for Social Services’;

and

(C) by adding at the end the following:

‘Subtitle B—Elder Justice’

SEC. 2011. DEFINITIONS.

In this subtitle:

(1) ABUSE.—The term ‘abuse’ means the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.

(2) ADULT PROTECTIVE SERVICES.—The term ‘adult protective services’ means such services provided to adults as the Secretary may specify by regulations such as—

(A) receiving reports of adult abuse, neglect, or exploitation;

(B) investigating the reports described in subparagraph (A);

(C) case planning, monitoring, evaluation, and other case work services; and

(D) providing, arranging for, or facilitating the provision of medical, social services, economic, legal, housing, law enforcement, or other protective, emergency, or support services.

(3) CAREGIVER.—The term ‘caregiver’ means an individual who has the responsibility for the care of an elder, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law, and includes a family member or other individual who provides, on behalf of such individual or of a public or private agency, organization, or institution, uncompensated or uncompensated care to an elder who needs supportive services in any setting.

The term ‘direct care’ means care by an employee or contractor who provides assistance or long-term care services to a recipient.

(4) ELDER.—The term elder means an individual age 60 or older.

(5) ELDERS JUSTICE.—The term ‘elders justice’ means—

(A) from a societal perspective, efforts to—

(i) prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and

(ii) protect elders with diminished capacity while maximizing their autonomy; and

(B) from an individual perspective, the recognition of an elder’s rights, including the right to be free of abuse, neglect, and exploitation.

(6) ELIGIBLE ENTITY.—The term ‘eligible entity’ means a State or local government agency, Indian tribe or tribal organization, or any other public or private entity that is engaged in and has expertise in issues relating to elder justice or in a field necessary to promote elder justice efforts.

(7) EXPLOITATION.—The term ‘exploitation’ means the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or support.

(8) FIDUCIARY.—The term ‘fiduciary’ means—

(A) a person or entity with the legal responsibility to—

(i) make decisions on behalf of and for the benefit of another person; and

(ii) to act in good faith and with fairness; and

(B) includes a trustee, a guardian, a conservator, an executor, an agent under a power of attorney, or any other public or private entity that is engaged in and has expertise in issues relating to elder justice or in a field necessary to promote elder justice efforts.

(9) GOVERNMENT.—The term ‘government’ includes—

(A) any State or local government agency;

(B) any Indian tribe or tribal organization;

(C) any public or private entity that is engaged in and has expertise in issues relating to elder justice or in a field necessary to promote elder justice efforts.

(10) GRANT.—The term grant includes a contract, cooperative agreement, or other mechanism for providing financial assistance.

(11) GUARDIAN.—The term ‘guardian’ means—

(A) the person by whom the property of an individual is administered;

(B) the manner in which the court appoints a guardian or determines who is the appropriate individual to act as guardian for an individual;

and

(C) the manner in which the court exercises oversight of the surrogate decisionmaker.

(12) INDIAN TRIBE.—

(A) IN GENERAL.—The term ‘Indian tribe’ has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 459b).

(B) INCLUSION OF PUEBLO AND RANCHERIA.—The term ‘Indian tribe’ includes any Pueblo or Rancheria.

(13) LAW ENFORCEMENT.—The term ‘law enforcement’ means the full range of potential responders to elder abuse, neglect, and exploitation including—

(A) police, sheriffs, detectives, public safety officers, and corrections personnel;

(B) prosecutors;

(C) medical examiners;

(D) investigators; and

(E) coroners.

(14) LONG-TERM CARE,—
...his or her religion through reliance on prayer alone for healing when this choice—
(e) is contemporaneously expressed, either orally or in writing, with respect to a specific health care decision, and the elder has not changed the time of the decision by an elder who is competent at the time of the decision;
(f) is previously set forth in a living will, health care proxy, or other advance directive document that is validly executed and applied under State law; or
(g) may be unambiguously deduced from the elder’s telephone.

**PART I—NATIONAL COORDINATION OF ELDER JUSTICE ACTIVITIES AND RESEARCH**

**Subpart A—Elder Justice Coordinating Council and Advisory Board on Elder Abuse, Neglect, and Exploitation**

(a) Establishment.—There is established within the Office of the Secretary an Elder Justice Coordinating Council (in this section referred to as the ‘Council’).

(b) Membership.—

(i) In general.—The Council shall be composed of the following members:

(A) The Secretary (or the Secretary’s designee).

(B) The Attorney General (or the Attorney General’s designee).

(C) The head of each Federal department or agency or other governmental entity identified by the Chair referred to in subsection (d) as having responsibilities, or administering programs relating to elder abuse, neglect, and exploitation.

(ii) Requirement.—Each member of the Council shall be a Federal officer or employee of the Federal Government.

(c) Vacancies.—Any vacancy in the Council shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

(d) Chair.—The member described in subsection (b)(1)(A) shall be Chair of the Council.

(e) Meetings.—The Council shall meet at least 2 times per year, as determined by the Chair.

(f) Duties.—

(i) In general.—The Council shall make recommendations to the Secretary for the development, coordination of, and coordination to the Federal Government’s responsibilities, or administering programs relating to elder abuse, neglect, and exploitation.

(ii) Requirement.—Each member of the Council shall be a Federal officer or employee of the Federal Government.

(g) Powers of the Council.—

(i) Information from Federal Agencies.—Subject to the requirements of section 202(a), the Council may secure directly from any Federal department or agency such information as the Council considers necessary to carry out this section. Upon request of the Chair of the Council, the head of such department or agency shall furnish such information to the Council.

(ii) Postal services.—The Council may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(b) Travel Expenses.—The members of the Council shall be reimbursed at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Council. The members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Council. Notwithstanding section 34 of title 5, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Council.

(c) Details of Government Employees.—Any Federal Government employee may be detailed to the Council or to the Advisory Board, and such detail shall be without interruption or loss of civil service status or privilege.

(d) Status as Permanent Council.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Council.

(e) Authorization of Appropriations.—There are authorized to be appropriated such sums as are necessary to carry out this section.

**Subpart B—Advisory Board on Elder Abuse, Neglect, and Exploitation**

(a) Establishment.—There is established a board to be known as the ‘Advisory Board on Elder Abuse, Neglect, and Exploitation’ (in this section referred to as the ‘Advisory Board’) to create short- and long-term multi-disciplinary strategic plans for the development of the field of elder justice and to make recommendations to the Elder Justice Coordinating Council established under section 203.

(b) Composition.—The Advisory Board shall be composed of 7 members appointed by the Secretary from among members of the general public who are individuals with experience and expertise in elder abuse, neglect, and exploitation prevention, detection, treatment, intervention, or prosecution.

(c) Solicitation of Nominations.—The Secretary shall publish a notice in the Federal Register soliciting nominations for the appointment of members of the Advisory Board under subsection (b).

(d) Terms.—

(i) In general.—Each member of the Advisory Board shall be appointed for a term of 3 years, except that, of the members first appointed—

(A) 3 shall be appointed for a term of 3 years;

(B) 3 shall be appointed for a term of 2 years; and

(C) 1 shall be appointed for a term of 1 year.

(ii) Vacancies.—

(A) A vacancy shall be filled on the expiration of the unexpired term of the member replaced.

(B) Filling Unexpired Term.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

(C) Expiration of Terms.—The term of any member shall not expire before the date on which the member’s successor takes office.

(d) Election of Officers.—The Advisory Board shall elect a Chair and Vice Chair from among its members. The Advisory Board shall elect its initial Chair and Vice Chair at its initial meeting.

(e) Meetings.—

(i) Enhance Communication on Promoting Quality of, and Preventing Abuse, Neglect, and...
AND EXPLOITATION IN, LONG-TERM CARE.—The Advisory Board shall develop collaborative and innovative approaches to improve the quality of, including preventing abuse, neglect in, long-term care.

"(2) COLLABORATIVE EFFORTS TO DEVELOP CONSENSUS AROUND THE MANAGEMENT OF CERTAIN QUALITY-RELATED FACTORS.—

(A) The Advisory Board shall establish multidisciplinary panels to address, and develop consensus on, subjects relating to improving the quality of long-term care. At least 1 such panel shall address, and develop consensus on, methods for managing resident-to-resident abuse in long-term care.

(B) ACTIVITIES CONDUCTED.—The multidisciplinary panels established under subparagraph (A) shall examine relevant research findings and best practices related to the subject of the panel, determine the best way to carry out those best practices in a practical and feasible manner, and determine an effective manner of distributing information on such subject.

"(3) REPORT.—Not later than the date that is 18 months after the date of enactment of the Elder Justice Act of 2009, and annually thereafter, the Advisory Board shall prepare and submit to the Elder Justice Coordinating Council, the Committee on Finance of the Senate Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing—

(A) information on the status of Federal, State, and local policies and public and private elder justice activities;

(B) recommendations (including recommended priorities) regarding—

(i) elder justice programs, research, training, services, practice, enforcement, and coordination; and

(ii) coordination between entities pursing elder justice efforts and those involved in related areas that may inform or overlap with elder justice efforts, such as activities to combat violence against women and child abuse and neglect; and

(iii) activities relating to adult fiduciary systems, including guardianship and other fiduciary arrangements;

(C) recommendations for specific modifications needed in Federal and State laws (including regulations) or for programs, research, and training to enhance prevention, detection, and treatment (including diagnosis) of, and intervention in (including investigations) and the protection of elder abuse, neglect, and exploitation;

(D) recommendations on methods for the most effective coordinated national data collection with respect to elder justice, and elder abuse, neglect, and exploitation; and

(E) recommendations for a multidisciplinary strategic plan to guide the effective and efficient development of the field of elder justice.

"(g) POWERS OF THE ADVISORY BOARD.—

(1) AUTHORITY TO FORM FEDERAL AGENCIES.—Subject to the requirements of section 1232(a), the Advisory Board may secure directly from any Federal department or agency such information as the Advisory Board considers necessary to carry out this section. Upon request of the Chair of the Advisory Board, the head of such department or agency shall furnish such information to the Advisory Board.

"(2) SHARING OF DATA AND REPORTS.—The Advisory Board may request from any entity pursuing elder justice efforts activities under the Elder Justice Act of 2009 or an amendment made by that Act, any data, reports, or recommendations generated in connection with such activities.

"(3) POSTAL SERVICES.—The Advisory Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

"(h) TRAVEL EXPENSES.—The members of the Advisory Board shall receive compensation for the performance of services for the Advisory Board. The members shall be allowed travel expenses for up to 4 meetings per year and shall be reimbursed for expenses of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes in the performance of services for the Advisory Board. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept, probate, and pay, out of funds appropriated for the performance of services for the Advisory Board.

"(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Advisory Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

"(j) STATUS AS PERMANENT ADVISORY COMMITTEE.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the advisory board.

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

SEC. 203. RESEARCH PROTECTIONS.

"(a) GUIDELINES.—The Secretary shall promulgate guidelines to assist researchers working in the area of elder abuse, neglect, and exploitation, with issues relating to human subject protections.

"(b) DEFINITION OF LEGALLY AUTHORIZED REPRESENTATIVE.—For purposes of the application of part A of title 46 of title 45, Code of Federal Regulations, to research conducted under the term ‘legally authorized representative’ means, unless otherwise provided by law, the individual or other body authorized under the applicable law to consent to medical treatment on behalf of another person.

"(c) MOBILE CENTERS.—The Secretary shall coordinate activities for individuals to train for and seek employment providing direct care in long-term care.

"(d) DEVELOPMENT OF FORENSIC EXPERTISE.—An eligible entity that receives a grant under this Act shall use funds made available through the grant to develop forensic expertise in forensics or commitment to professional development or forensic evaluation, therapeutic intervention, victim support and advocacy, case review, and case tracking.

"(3) COLLECTION OF EVIDENCE.—The Secretary, in coordination with the Attorney General, shall use data made available by grant recipients under this section to develop the capacity of geriatric health care professionals and law enforcement to collect forensic evidence, including collecting forensic evidence relating to the determination of elder abuse, neglect, and exploitation in order to provide medical and forensic evaluation, therapeutic intervention, victim support and advocacy, case review, and case tracking.

"(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) for fiscal year 2011, $4,000,000; and

(2) for each of fiscal years 2012 through 2014, $8,000,000.

PART II—PROGRAMS TO PROMOTE ELDER JUSTICE

SEC. 204. ENHANCEMENT OF LONG-TERM CARE.

"(a) GRANTS AND INCENTIVES FOR LONG-TERM CARE STAFFING.—

(1) IN GENERAL.—The Secretary shall carry out this section, including activities described in paragraphs (2) and (3), to provide incentives for individuals to seek, and maintain employment providing direct care in long-term care.

(2) SPECIFIC PROGRAMS TO ENHANCE TRAINING, RECRUITMENT, AND RETENTION OF STAFF.—

(A) COORDINATION WITH SECRETARY OF LABOR TO RECRUIT AND TRAIN LONG-TERM CARE STAFF.—The Secretary shall coordinate activities under this subsection with the Secretary of Labor in order to provide incentives for individuals to train for and seek employment providing direct care in long-term care.

(B) CAREER LADDERS AND BONUS INCREASES TO INCREASE STAFFING IN LONG-TERM CARE.—

(1) IN GENERAL.—The Secretary shall make grants to eligible entities to carry out programs through which the entities—

(a) offer, to employees who provide direct care to residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity, continuing training and varying levels of certification, based on observed clinical care practices and the amount of time the employees spend providing direct care; and

(b) may, provide, or make arrangements to provide, bonuses or other increased compensation or benefits to employees who achieve certification under such a program.

(2) AUTHORIZED ACTIVITIES.—

(I) DEVELOPMENT OF FORENSIC MARKERS AND METHODOLOGIES.—An eligible entity that receives a grant under this subparagraph, an eligible entity shall submit an application to develop forensic expertise in forensics or commitment to professional development or forensic evaluation, therapeutic intervention, victim support and advocacy, case review, and case tracking.
the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

(iii) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subsection shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subparagraph.

(c) TECHNIQUES TO IMPROVE MANAGEMENT PRACTICES.—

(A) IN GENERAL.—The Secretary shall make funds available under this subparagraph to enable the entities to provide training and technical assistance.

(B) AUTHORIZED ACTIVITIES.—An eligible entity shall receive a grant under subparagraph (A) to use funds made available through the grant to provide training and technical assistance regarding management practices using methods that are demonstrated to promote retention of individuals who provide direct care, such as—

(i) the establishment of standard human resource policies and procedures in place to accept the optional electronic transmission of prescription and patient information;

(ii) the establishment of motivational and thoughtful work organization practices;

(iii) the creation of a workplace culture that respects and values caregivers and their needs;

(iv) the promotion of a workplace culture that respects the rights of residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity and results in improved care for the residents or the individuals; and

(v) the establishment of other programs that promote the provision of high quality care, such as a continuing education program that provides additional hours of training, including on-the-job training, for employees who are certified nurse aides.

(C) APPLICATION.—To be eligible to receive a grant under this paragraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

(D) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subsection shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this paragraph.

(e) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection help improve patient safety and reduce adverse events and health care complications resulting from medication errors.

(f) ADOPTION OF STANDARDS FOR TRANSACTIONS INVOLVING CLINICAL DATA BY LONG-TERM CARE FACILITIES.—

(1) STANDARDS AND COMPATIBILITY.—The Secretary shall adopt electronic standards for the exchange of clinical data by long-term care facilities, including, where available, standards for messaging and nomenclature. Standards adopted by the Secretary under the preceding sentence shall be compatible with standards established under section 1860D–4, standards adopted under section 3004 of the Public Health Service Act, and general health information technology standards.

(2) ELECTRONIC SUBMISSION OF DATA TO THE SECRETARY.—

(A) IN GENERAL.—Not later than 10 years after the date of enactment of the Elder Justice Act of 2009, the Secretary shall have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities pursuant to the standards adopted under paragraph (1).

(B) RULE OF CONSTRUCTION .—Nothing in this subsection shall be construed to require a long-term care facility to submit clinical data electronically to the Secretary.

(C) MAKEUP OF PROFESSIONAL STANDARDS COMMITTEE.—

(i) APPOINTMENT .—The Secretary shall promulgate regulations to carry out this subsection. Such regulations shall include a State, as a condition of the receipt of funds under this part, to conduct such data collection and reporting activity that determine the number of respondents necessary to satisfy the requirements of this subsection.

(ii) REPORT TO THE SECRETARY.—There are authorized to be appropriated to carry out this section—

(A) for fiscal year 2011, $20,000,000;

(B) for fiscal year 2012, $17,500,000; and

(C) for each of fiscal years 2013 and 2014, $15,000,000.
expended to provide adult protective services in the State.

(4) STATE REPORTS.—Each State receiving funds under this subsection shall submit to the Secretary, such time and in such manner as the Secretary may require, a report on the number of elders served by the grants awarded under this subsection.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $100,000,000 for each of fiscal years 2011 through 2014.

SEC. 2041. ELDER JUSTICE PROGRAMS.

(a) General Provisions.—There are authorized to be appropriated to carry out this section, in each of fiscal years 2011 through 2014, $10,000,000.

(b) Authorization of Appropriations.—

(1) Authorization of Appropriations.—There are authorized to be appropriated to carry out this subsection, for each of fiscal years 2011 through 2014, $10,000,000.

(2) Authorization of Appropriations.—

(a) Provision of Information.—To be eligible to receive a grant under this part, an applicant shall agree—

(1) except as provided in paragraph (2), to provide the eligible entity carrying out the demonstration program with such information as the eligible entity may require in order to conduct such evaluation; or

(2) in the case of a grant under section 2041(b), to provide the Secretary with such information as the Secretary may require to conduct an evaluation or audit under subsection (c).

(b) Use of Eligible Entities To Conduct Evaluations.—

(1) Evaluations Required.—Except as provided in paragraph (2), the Secretary shall—

(A) reserve a portion (not less than 2 percent) of the funds appropriated with respect to each program carried out under this part, and

(B) use the funds reserved under subparagraph (A) to provide assistance to eligible entities with such information as the Secretary determines to be appropriate under this subsection.

(c) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(d) State Demonstration Programs.—Funds made available pursuant to this subsection may be provided for demonstration programs in accordance with paragraph (2).

(e) Demonstration Programs.—Funds made available pursuant to this subsection may be provided for demonstration programs in accordance with paragraph (2).

(f) Use of Funds.—Funds made available pursuant to this subsection may be provided for demonstration programs in accordance with paragraph (2).

(g) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(h) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(i) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(j) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(k) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(l) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(m) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(n) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(o) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(p) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(q) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(r) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(s) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(t) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(u) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(v) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(w) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(x) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(y) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(z) Authorized Activities.—A recipient of a grant under section 2041(b), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(A) General.—The Secretary shall establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for organizations and State long-term care ombudsman programs.

(2) Authorization of Appropriations.—

(a) General.—There are authorized to be appropriated to carry out this subsection, $10,000,000.

(b) Authorization of Appropriations.—

(1) Authorization of Appropriations.—There are authorized to be appropriated to carry out this subsection, $10,000,000.

(2) Authorization of Appropriations.—

(a) General.—There are authorized to be appropriated to carry out this subsection, $10,000,000.

(b) Authorization of Appropriations.—

(1) Authorization of Appropriations.—There are authorized to be appropriated to carry out this subsection, $10,000,000.

(2) Authorization of Appropriations.—

(a) General.—There are authorized to be appropriated to carry out this subsection, $10,000,000.

(b) Authorization of Appropriations.—

(1) Authorization of Appropriations.—There are authorized to be appropriated to carry out this subsection, $10,000,000.
(vii) Analyze and report annually on the following:
   (I) The total number and sources of complaints of such abuse, neglect, and misappropriation of property.
   (II) The extent to which such complaints are referred to law enforcement agencies.
   (III) The extent of Federal and State investigations of such complaints.
   (viii) Conduct a national study of the cost to States of conducting initial investigations of skilled nursing facilities and nursing facilities under sections 1819 and 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1396r), and make recommendations to the Secretary of Health and Human Services with respect to options to increase the efficiency and cost-effectiveness of such investigations.
   (C) Authorization.—There are authorized to be appropriated to carry out this paragraph, for the period of fiscal years 2011 through 2014, $5,000,000.

(2) GRANTS TO STATE SURVEY AGENCIES.—
   (A) IN GENERAL.—The Secretary of Health and Human Services shall make grants to State agencies that perform surveys of skilled nursing facilities or nursing facilities under sections 1819 or 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1396r), for the period of fiscal years 2011 through 2014, $12,000,000.
   (B) USE OF FUNDS.—A grant awarded under subparagraph (A) shall be used for the purpose of designing and implementing complaint investigations systems that—
      (i) promptly prioritize complaints in order to ensure a rapid response to the most serious and urgent complaints;
      (ii) respond to complaints with optimum effectiveness and timeliness; and
      (iii) optimize the collaboration between local authorities, consumers, and providers, including—
         (I) such State agency;
         (II) the State Long-Term Care Ombudsman;
         (III) local law enforcement agencies;
         (IV) advocacy and consumer organizations;
         (V) State aging units;
         (VI) Area Agencies on Aging; and
         (VII) other appropriate entities.
   (C) Authorization.—There are authorized to be appropriated to carry out this paragraph, for each of fiscal years 2011 through 2014, $5,000,000.

(3) REPORTING OF CRIMES IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES.—
   (A) IN GENERAL.—The Secretary, in consultation with appropriate government agencies and private sector organizations, shall conduct a study on establishing a national nurse aide registry.
   (B) STUDY AND REPORT.—
      (i) CONTENT.—The study conducted under this subsection shall include an evaluation of—
         (I) who should be included in the registry;
         (II) how such a registry would comply with Federal and State privacy laws and regulations;
         (III) how data would be collected for the registry;
         (IV) what entities and individuals would have access to the data collected;
         (v) how the registry would provide appropriate information regarding violations of Federal and State law by individuals included in the registry;
         (vi) how the functions of a national nurse aide registry would be coordinated with the nationwide program for national and State background checks on direct patient access employees of long-term care facilities and providers under section 3001; and
         (vii) how the information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i–3(e)(2); 1396r(e)(2)(D)) would be provided as part of a national nurse aide registry.
      (ii) CONSIDERATIONS.—In conducting the study and preparing the report required under this subsection, the Secretary shall take into consideration the findings and conclusions of relevant reports and other relevant documents and resources, including—
         (I) The Department of Health and Human Services Office of Inspector General Report,

(ii) The General Accounting Office (now known as the Government Accountability Office) by inserting "substitute 1 can be done to Protect Residents from Abuse (March 2002)."


(v) The 2001 Report to CMS from the School of Rural Public Health, Texas A&M University, Preventing Abuse and Neglect in Nursing Homes: The Role of Nurse Aide Registries.

(vi) Information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1396i-3(e)(2); 1396r(e)(2)(2)).

D Report.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to the Elder Abuse Coordinating Council established under section 2021 of the Social Security Act, as added by section 128(a), the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing the findings and recommendations of the study conducted under this paragraph.

E Funding Limitation.—Funding for the study conducted under this subsection shall not exceed $500,000.

3 Congressional Action.—After receiving the report submitted by the Secretary under paragraph 2(d), the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives shall, as they deem appropriate, take action based on the recommendations contained in the report.

4 Authorization of Appropriations.—There are authorized to be appropriated such sums as are necessary for the purpose of carrying out this subsection.

D Conforming Amendments.—

(1) Title XX.—Title XX of the Social Security Act (42 U.S.C. 601 et seq.) is amended—

(A) in section 1128(h)(3)—

(i) by inserting "subtitle 1 of" before "title XX";

(ii) by striking "such title" and inserting "such subtitle"; and

(iii) by striking "section 1128(a)(1), by inserting "subtitle 1 of" before "title XX".

Subtitle A—The Senate Regarding Medical Malpractice

SEC. 5501. SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE.

It is the sense of the Senate that—

(1) health care providers have an opportunity to address issues related to medical malpractice and medical liability insurance;

(2) States should be encouraged to develop and test alternative civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court; and

(3) Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims.

TITLE VI—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

Subtitle A—Biologics Price Competition and Innovation Act of 2009

SEC. 6001. SHORT TITLE.

(a) In General.—This subtitle may be cited as the "Biologics Price Competition and Innovation Act of 2009".

(b) Sense of the Senate.—The sense of the Senate is that a biosimilars pathway balancing innovation and consumer interests should be established.

SEC. 6002. APPROVAL PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) License of Biological Products as Biosimilar or Interchangeable.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting "under this subsection or subsection (k)" after "biologics license"; and

(2) by adding at the end the following:

"(k) License of biological products as biosimilar or interchangeable.—(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

(2) CONTENT.—

(A) In general.—

(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

(I) the biological product is biosimilar to the reference product based upon data derived from—

(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

(bb) animal studies (including the assessment of toxicity); and

(cc) a clinical study or studies (including the assessment of immunogenicity and pharmacodynamics) that are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which licensure is sought for the biological product;

(II) the biological product and reference product are the same as those of the reference product; and

(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

(iv) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

(v) the facility in which the biological product is manufactured, processed, packaged, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent;

(ii) DETERMINATION BY SECRETARY.—The Secretary may determine, in the Secretary's discretion, that an element described in clause (i) of paragraph (1) of this subsection is not included in an application submitted under this subsection.

(iii) ADDITIONAL INFORMATION.—An application submitted under this subsection—

(I) shall include publicly-available information regarding the Secretary's previous determination that the reference product is safe, pure, and potent; and

(II) may include information in support of the application, including publicly-available information with respect to the reference product or another biological product.

(iv) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this subsection may include information demonstrating that the biological product meets the standards described in paragraph (4).

(v) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

(I) is biosimilar to the reference product; or

(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

(B) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alteration or switch.

"(g) General Rules.—

(1) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

(B) REVIEW.—An application submitted under this subsection shall be reviewed by
the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

(4) Guidance documents.—(A) In general.—The Secretary may, at any time, issue or withdraw or modify, or delay the issuance of, any guidance document issued under subparagraph (A) before issuing final guidance.

(1) In general.—The Secretary shall provide the public with an opportunity to comment on any guidance document issued under subparagraph (A) before issuing final guidance.

(2) Public notice.—The Secretary shall provide public notice of any modification or withdrawal of a guidance document issued under subparagraph (A) before issuing final guidance.

(3) Input regarding most valuable guidance.—The Secretary shall establish a process through which the public may provide the Secretary with input regarding priorities for guidance issuance.

(4) No requirement for application consideration.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

(5) Requirement for product class-specific guidance.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

(ii) the criteria, if available, that the Secretary will use to determine whether a biological product is interchangeable for any condition of use, the Secretary has not been sued under subsection (a).

(c)(1) Effectiveness for first interchangeable biological product.—Upon review of an application submitted under this subsection relying on the same reference product for which the biological product has been determined to be interchangeable for any condition of use, the Secretary shall make a determination under paragraph (2) and any other information required to be produced pursuant to paragraph (2) and any other information required to be produced pursuant to subparagraph (B) shall disclose any information relevant or related to the reference product and who has retained a right to assert the patent or participate in litigation concerning the patent may be provided the confidential information, provided that the representative information shall be released to the representative of the owner of a patent exclusively licensed to a reference product sponsor who is an employee of an entity other than the reference product sponsor. (referred to in this paragraph as the 'outside counsel').

(2) In general.—One or more attorneys designated by a reference product sponsor who are employees of an entity other than the reference product sponsor, (referred to in this paragraph as the 'outside counsel'), may redesignate confidential information received under this paragraph, in whole or in part, in confidence under subparagraph (B) shall disclose any information relevant or related to the reference product.

(3) Outside counsel.—One or more attorneys designated by a reference product sponsor who is an employee of a reference product sponsor, (referred to in this paragraph as the 'outside counsel'), may redesignate confidential information received under this paragraph, in whole or in part, in confidence under subparagraph (B) shall disclose any information relevant or related to the reference product.

(4) Patent owner access.—A representative of the owner of a patent exclusively licensed to a reference product sponsor with respect to the reference product and who has retained a right to assert the patent or participate in litigation concerning the patent may provide the confidential information, provided that the representative information shall be released to the representative of the owner of a patent exclusively licensed to a reference product sponsor who is an employee of an entity other than the reference product sponsor, (referred to in this paragraph as the 'outside counsel'), may redesignate confidential information. In the event that the reference product sponsor files a patent infringement suit, the use of confidential information shall continue to be governed by the terms of this paragraph until such time as a court enters a protective order regarding the information. Upon entry of such order, the subsection (k) applicant may redesignate confidential information in accordance with the terms of that order. No confidential information shall be included in any publicly-available complaint or other pleading. In the event that the reference product sponsor does not file an infringement action by the date specified in subparagraph (A), the reference product sponsor shall return or destroy all confidential information received under this paragraph.
“(G) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

“(i) as an admission by the subsection (k) applicant regarding the validity, enforceability, or infringement of any patent listed by the subsection (k) applicant;

“(ii) as an agreement or admission by the subsection (k) applicant with respect to the competency, relevance, or materiality of any confidentiality information.

“(H) EFFECT OF VIOLATION.—The disclosure of any confidential information in violation of this paragraph shall be deemed to cause the subsection (k) applicant to suffer irreparable harm for which there is no adequate legal remedy and the court shall consider immediate injunctive relief to be appropriate and necessary remedy for any violation or threatened violation of this paragraph.

“SUBSECTION (K) APPLICATION INFORMATION.—Not later than 20 days after the Secretary notifies the subsection (k) applicant that the application has been accepted for review, the subsection (k) applicant—

“(A) shall provide to the reference product sponsor a copy of the application submitted to the Secretary under subsection (k), and such other information that describes the process or processes used to manufacture the biological product that is the subject of such application; and

“(B) may provide to the reference product sponsor additional information requested by or on behalf of the reference product sponsor.

“(I) LIST AND DESCRIPTION OF PATENTS.—

“EXCHANGE OF PATENT LISTS.—

“(A) NUMBER OF PATENTS.—The subsection (k) applicant shall notify the reference product sponsor of the number of patents that such applicant will provide to the reference product sponsor under subparagraph (B)(i) if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application; and

“(B) EXCHANGE OF PATENT LISTS.—

“(i) in general.—Not later than 60 days after the receipt of the application and information under paragraph (2), the reference product sponsor shall provide to the subsection (k) applicant—

“(I) a list of patents for which the reference product sponsor believes should be the subject of an action for patent infringement under paragraph (3)(A); and

“(II) a statement that the subsection (k) applicant believes should be the subject of an action for patent infringement under paragraph (3)(B).

“(ii) the number of patents listed by the subsection (k) applicant and the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6).

“(C) DESCRIPTION BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after the receipt of the application and information under paragraph (2), the reference product sponsor shall provide to the subsection (k) applicant—

“(i) a detailed statement that describes, on a claim by claim basis, the factual and legal basis of the opinion of the subsection (k) applicant regarding the validity, enforceability, or patent infringement with respect to each such patent.

“(ii) a statement that the subsection (k) applicant does not intend to begin commercial marketing of the biological product before the date that such patent expires; and

“(iii) shall provide to the reference product sponsor a response regarding each patent that the subsection (k) applicant believes should be the subject of an action for patent infringement under subparagraph (A)(i).

“(D) DESCRIPTION BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after receipt of the application and information under subparagraph (B), the reference product sponsor shall provide to the subsection (k) applicant a detailed statement that describes, with respect to each patent identified by the reference product sponsor under paragraph (B)(i)(II), on a claim by claim basis, the factual and legal basis of the opinion that the reference product sponsor believes should be the subject of an action for patent infringement with respect to each such patent.

“(E) PATENT RESOLUTION NEGOTIATIONS.—

“(A) IN GENERAL.—After receipt by the subsection (k) applicant of the statement under paragraph (3)(C), the reference product sponsor and the subsection (k) applicant shall engage in good faith negotiations to agree on a list of patents under subparagraph (A) in accordance with paragraph (3)(B).

“(B) EXCHANGE OF PATENT LISTS.—

“(I) In general.—Subject to subclause (II), the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6), the reference product sponsor shall provide to the subsection (k) applicant a list of patents to which the subsection (k) applicant believes should be the subject of an action for patent infringement under paragraph (6).

“(ii) if the subsection (k) applicant does not list any patent under clause (i)(I), the reference product sponsor may list 1 patent under clause (i)(II).

“(C) REASONABLE COOPERATION.—If the reference product sponsor fails to agree on a final and complete list of patents under paragraphs (3)(A), the subsection (k) applicant and the reference product sponsor shallmediates an action for patent infringement under paragraph (6).

“(D) PATENT RESOLUTION NEGOTIATIONS.—

“(A) IN GENERAL.—After receipt by the subsection (k) applicant of the statement under paragraph (3)(C), the reference product sponsor and the subsection (k) applicant shall engage in good faith negotiations to agree on a list of patents under subparagraph (A) in accordance with paragraph (3)(B).

“(B) EXCHANGE OF PATENT LISTS.—

“(I) In general.—Subject to subclause (II), the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6), the reference product sponsor shall provide to the subsection (k) applicant a list of patents to which the subsection (k) applicant believes should be the subject of an action for patent infringement under paragraph (6).

“(ii) if the subsection (k) applicant does not list any patent under clause (i)(I), the reference product sponsor may list 1 patent under clause (i)(II).

“(E) IMMEDIATE PATENT INFRINGEMENT ACTION.—

“(A) ACTION IF AGREEMENT ON PATENT LIST.—If the subsection (k) applicant and the reference product sponsor agree on patents under clause (i)(I) or in the list provided by the subsection (k) applicant under paragraph (3)(A), and the subsection (k) applicant shall bring an action for patent infringement with respect to each such patent.

“(B) ACTION IF NO AGREEMENT ON PATENT LIST.—If the provisions of paragraph (5) are not met, the paragraphs of an action for patent infringement under paragraph (6), the reference product sponsor shall bring an action for patent infringement with respect to each patent that is included on such lists.

“(C) NOTIFICATION OF PUBLICATION OF COMPLAINT.—

“(1) NOTIFICATION TO SECRETARY.—Not later than 30 days after a complaint is served to a subsection (k) applicant in an action for patent infringement described under paragraphs (4)(A) and (5), the reference product sponsor shall provide the Secretary with notice and a copy of such complaint.

“(ii) the list of patents described in paragraph (3)(C) that includes such patent, not later than 30 days after such supplement is provided, the subsection (k) applicant shall provide to the reference product sponsor under paragraph (3)(A) a list of patents that includes such patent, not later than 30 days after such supplement is provided, the subsection (k) applicant shall cause to be published a list of the patents by the Secretary under subparagraph (B), and patent shall be subject to paragraph (8).

“(D) NOTICE OF COMMERCIAL MARKETING AND PRELIMINARY INJUNCTION.—

“(A) NOTICE OF COMMERCIAL MARKETING.—The subsection (k) applicant shall provide notice to the reference product sponsor not later than 30 days before the first commercial marketing of the biological product licensed under subsection (k).

“(B) PRELIMINARY INJUNCTION.—After receipt of the notice under paragraph (A) and before such date of first commercial marketing of such biological product, the reference product sponsor may seek a preliminary injunction prohibiting the subsection (k) applicant from engaging in the commercial manufacture or sale of such biological product until the court determines the issue of patent validity, enforceability, and infringement with respect to any patent that is—

“(i) included in the list provided by the reference product sponsor under paragraph (3)(A) or in the list provided by the subsection (k) applicant under paragraph (3)(B); and

“(ii) not included, as applicable, on—

“(i) the list of patents described in paragraph (4); or

“(ii) the lists of patents described in paragraph (B).

“(C) REASONABLE COOPERATION.—If the reference product sponsor has sought a preliminary injunction under subparagraph (B), the reference product sponsor and the subsection (k) applicant shall reasonably cooperate to expedite such further discovery as is needed
in connection with the preliminary injunction motion.

“(9) LIMITATION ON DECLARATORY JUDGMENT

—

(A) SUBSECTION (k) APPLICATION PRO-

VIDED.—If a subsection (k) applicant provides the application and information required under paragraph (2)(A), neither the reference product nor the subsection (k) applicant may, prior to the date notice is received under paragraph (8)(A), bring any action under section 228 of title 28, United States Code, for a declaratory judgment of infringement, valid-

ity, or enforceability of any patent that is described in clauses (i) and (ii) of paragraph (8)(B).

(B) SUBSEQUENT FAILURE TO ACT BY SUB-

SECTION (k) APPLICANT.—If a subsection (k) applicant fails to complete an action re-

quired of the subsection (k) applicant under paragraph (9)(B)(i), paragraph (6)(A), or paragraph (6)(A)(i), the reference product sponsor, but not the subsection (k) applicant, may bring an ac-

tion under section 228 of title 28, United States Code, for a declaration of infringe-

ment, validity, or enforceability of any patent included in the list described in para-

graph (A), including as provided under paragraph (7).

(C) SUBSECTION (k) APPLICATION NOT PRO-

VIDED.—If a subsection (k) applicant fails to provide the application and information re-

quired under paragraph (2)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 228 of title 28, United States Code, for a dec-

laration of infringement, validity, or en-

forceability of any patent that claims the bi-

ological product or a use of the biological product.

(b) DEFINITIONS.—Section 351(i) of the Pub-

lic Health Service Act (42 U.S.C. 262(i)) is amended—

(1) by striking “In this section, the term ‘biological product’ means” and inserting the following: “In this section:

(1) The term ‘biological product’ means’;

(2) in paragraph (1), as so designated, by in-

serting “protein (except any chemically syn-

thesized polypeptide),” after “allergenic

product’; and

(3) by striking at the end; the following:

“(2) The term ‘biosimilar’ or ‘biosimi-

larity’, in reference to a biological product that is the subject of an application under subsection (a) of such Act, means that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive genetic control elements;

“(B) there are no clinically meaningful dif-

ferences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

(3) The term ‘interchangeable’ or ‘inter-

changeability’, in reference to a biological product that is shown to meet the standards described in subsection (k)(4), means that the biological product may be substituted for the reference product without the interven-

tion of the health care provider who pre-

scribed the reference product;

“(4) The term ‘reference product’ means the single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k)’.

(c) CONFORMING AMENDMENTS RELATING TO PATENTS

(1) PATENTS.—Section 271(e) of title 35,

United States Code, is amended—

(A) in paragraph (2)—

(i) in subparagraph (A), by striking “or” at the end; and

(ii) in subparagraph (B), by adding “or” at the end; and

(iii) by inserting after subparagraph (B) the following:

“(C)(i) with respect to a patent that is identified in the list of patents described in section 351(k)(4) of the Public Health Service Act (including as provided under section 351(k)(7) of such Act), an application seeking approval of a biological product, or

(ii) if the application fails to provide the application and information required under section 351(k)(7) of such Act, an application seeking approval of a biological product for a patented that could be identified pursuant to section 351(k)(3)(A)(i) of such Act’; and

(iv) in the matter following subparagraph (C) as added by striking “the biological product, or biological product’; and

(B) in paragraph (4)—

(i) in subparagraph (B), by—

(I) striking “or veterinary biological prod-

uct” and inserting “veterinary biological product, or biological product’; and

(II) striking “and” at the end;

(ii) in subparagraph (C), by—

(I) striking “or veterinary biological pro-

duct’’ and inserting “veterinary biological product, or biological product’; and

(II) striking the period and inserting “.

(iii) by inserting after subparagraph (C) the following:

“(D) the court shall order a permanent in-

junction prohibiting any infringement of the patent by the biological product involved in the infringement until a date which is not earlier than the date of the expiration of the patent that would have been under parag-

raph (2)(C), provided the patent is the sub-

ject of a final court decision, as defined in section 351(k)(6) of the Public Health Service Act, in an action for infringement of the pat-

ent under section 351(k)(6) of such Act, and the biological product has not yet been ap-

proved because of section 351(k)(7) of such Act’’; and

(iv) in the matter following subparagraph (D) as added by clause (iii), by striking “and” and inserting “, and (D)”;

(B) Subparagraph (B) applies, in lieu of paragraph (4), in the case of a patent—

(1) that is identified, as applicable, in the list of patents described in section 351(1)(4) of the Public Health Service Act or the lists of patents described in section 351(1)(5)(B) of such Act with respect to a biological prod-

uct; and

(2) for which an action for infringement of the patent with respect to the biological product—

was brought after the expiration of the 30-day period described in subparagraph (A) or (B), as applicable, of section 351(1)(6) of such Act; or

was brought before the expiration of the 30-day period described in clause (1), but which was dismissed without prejudice or was not prosecuted to judgment in good faith.

(B) in an action for infringement of a patent described in subparagraph (A), the sole and exclusive remedy that may be granted by a court, upon a finding that the making, using, offering to sell, selling, or importa-

tion into the United States of the biological product that is the subject of such application infringed the patent, shall be a reasonable royalty.

(C) the owner of a patent that should have been included in the list described in section 351(1)(3)(A) of the Public Health Service Act, including as provided under section 351(1)(7) of such Act, for biological products, but was not timely included in such list, may not bring an action under this section for infringement of the patent with respect to the biological product’.

(2) CONFORMING AMENDMENT UNDER TITLE

28.—Section 229(b)(2) of title 28, United States Code, is amended by inserting before the per-

iod the following: “, or section 351 of the Public Health Service Act’’.

(d) CONFORMING AMENDMENTS UNDER THE

FEDERAL FOOD, DRUG, AND COSMETIC ACT.—

(1) CONTENT AND REVIEW OF APPLICATIONS.—

Section 506(b)(9)(B) of the Federal Food,

Drug, and Cosmetic Act (21 U.S.C. 355(b)(9)(B)) is amended by inserting before the per-

iod the following: “, or with respect to an appli-

cation for a biological product under section 351(k) of the Public Health Service Act, any necessary clinical study or studies.”

(2) NEW ACTIVE INGREDIENT.—Section 505(b)

of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355c) is amended by adding at the end the following:

“NEW ACTIVE INGREDIENT.—

“(1) NON-INTERCHANGEABLE BIOSIMILAR BIO-

LOGICAL PRODUCT.—A biological product that is biosimilar to a reference product under section 351 of the Public Health Service Act, and that the Secretary has not determined to meet the standards described in sub-

section (k)(4) of such section for interchangeability with the reference product, shall be considered to have a new active ingre-

dient under this section.

“(2) INTERCHANGEABLE BIOSIMILAR BIO-

LOGICAL PRODUCT.—A biological product that is interchangeable with a reference product under section 351 of the Public Health Serv-

ice Act shall not be considered to have a new active ingredient under this section.

(e) PRODUCTS PREVIOUSLY APPROVED UNDER

SECTION 351.—

(1) REQUIREMENT TO FOLLOW SECTION 351.—

Except as provided in paragraph (2), an appli-

cation for a biological product shall be sub-

mitted under section 351(k) of the Public Health Service Act (42 U.S.C. 262) as amended by this Act.

(2) EXCEPTION.—An application for a bio-

logical product may be submitted under sec-

tion 506 of the Federal Food, Drug, and Cosme-

tic Act (21 U.S.C. 355) if—

(A) such biological product is in a product class for which a biological product in the same product class is the subject of an application approved under section 506 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this subtitle as the ‘Secretary’) before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(f) WITHSTANDING paragraph (2), an applica-

tion for a biological product may not be submitted under section 506 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if the other a biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product with re-

spect to such application (within the mean-

ing of section 351) if such application were submitted under subsection (k) of such section.

(g) AMENDMENTS APPROVED UNDER SECTION 351.—

An approved application for a biological product under section 506 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) be deemed to be a biological product under such section 351 on the date that is 10 years after the date of enact-

ment of this Act.

(h) DEFINITIONS.—For purposes of this sub-

title, the term ‘biological product’ has the meaning given such term under section
351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act). (f) FOLLOW-ON BIOLOGICS USER FEES.—

(1) DEVELOPMENT OF USER FEES FOR BIO-
SIMILAR BIOLOGICAL PRODUCTS.—

(A) IN GENERAL.—Beginning not later than October 1, 2010, the Secretary shall develop recommendations to present to Congress with respect to the goals, and plans for meeting the goals, for the process for the review of biosimilar biological product applications submitted under section 351(k) of the Public Health Service Act (as added by this Act) for the first 5 fiscal years after fiscal year 2012. In developing such recommendations, the Secretary shall consult with—

(i) the Committee on Health, Education, Labor, and Pensions of the Senate;

(ii) the Committee on Energy and Commerce of the House of Representatives;

(iii) scientific and academic experts;

(iv) health care professionals;

(v) representatives of patient and consumer groups;

(vi) the regulated industry.

(B) PUBLIC REVIEW OF RECOMMENDATIONS.—After negotiations with the regulated industry, the Secretary shall—

(i) present the recommendations developed under subparagraph (A) to the Congressional committees and subcommittees in such subparagraph;

(ii) publish such recommendations in the Federal Register;

(iii) provide for a period of 30 days for the public to provide written comments on such recommendations;

(iv) hold a meeting at which the public may present its views on such recommendations;

and

(v) after consideration of such public views and comments, revise such recommendations as necessary.

(C) TRANSMITTAL OF RECOMMENDATIONS.—Not later than January 15, 2012, the Secretary shall transmit to Congress the revised recommendations under subparagraph (B), a summary of the views and comments received under such subparagraph, and any changes made to the recommendations in response to such views and comments.

(2) ESTABLISHMENT OF USER FEE PROGRAM.—It is the sense of the Senate that, based on the recommendations transmitted to Congress pursuant to paragraph (1)(C), Congress should authorize a program, effective on October 1, 2012, for the collection of user fees relating to the submission and review of applications under section 351(k) of the Public Health Service Act (as added by this Act).

(3) TRANSITIONAL PROVISIONS FOR USER FEES FOR FOLLOW-ON BIOLOGICAL PRODUCTS.—

(A) APPLICATION OF THE PRESCRIPTION DRUG USER FEE PROVISIONS.—Section 735(h)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379k(1)(B)) is amended by striking “section 351” and inserting “subsection (a) or (k) of section 351”.

(B) EVALUATION OF COSTS OF REVIEWING BIOSIMILAR BIOLOGICAL PRODUCT APPLICATIONS.—During the period beginning on the date of enactment of this Act and ending on October 1, 2012, the Secretary shall collect and evaluate data regarding the costs of reviewing applications for biological products submitted under section 351(k) of the Public Health Service Act (as added by this Act) during such period.

(C) AUDIT.—

(1) IN GENERAL.—On the date that is 2 years after first receiving a user fee applicable to an application for a biological product submitted under section 351(k) of the Public Health Service Act (as added by this Act), and on a biennial basis thereafter until October 1, 2013, the Secretary shall submit to the Committee on Appropriations of the Senate an audit of the costs of reviewing such applications under such section 351(k). Such an audit shall compare—

(I) the costs of reviewing such applications under such section 351(k) to the amount of the user fee applicable to such applications; and

(II) (aa) such ratio determined under sub-

clause (I); to

(bb) the ratio of the costs of reviewing ap-

applications for biological products under sec-

tion 351(a) of such Act (as amended by this

Act) to the amount of the user fee applicable
to such applications under such section 351(a).

(B) ALTERATION OF USER FEE.—If the audit

performed under clause (I) indicates that the ratios compared under subsection (II) of such

clause, or under subparagraph (A) to the

Secretary shall alter the user fee applicable
to applications submitted under such section

351(k) to more appropriately account for the

costs of reviewing such applications.

(C) ACCOUNTING STANDARDS.—The Sec-

retary shall perform an audit under clause (I)
in conformance with the accounting prin-

ciples, standards, and requirements pre-

scribed by the Comptroller General of the

United States under section 3511 of title 31,

United States Code, to ensure the validity of

any potential data needed for such audits.

(4) AUTHORIZATION OF APPROPRIATIONS.—

There is authorized to be appropriated to

carry out this subsection such sums as may be

necessary for each of fiscal years 2010 through 2012.

(5) PEDICULAR STUDIES OF BIO-

LOGICAL PRODUCTS.—

(A) IN GENERAL.—Section 351 of the Public

Health Service Act (42 U.S.C. 262) is amended

by adding at the end the following:

(5) PRECLAIM STUDIES.—(1) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (a), (d), (e), (f), (g), (h), (j), (k), (l), (m), and (n) of section 506A of the Federal Food, Drug, and Cosmetic Act shall apply with respect to the extension of a period under paragraphs (2) and (3) to the same extent and in the same manner as such provisions apply with respect to the extension of a period under subsection (b) or (c) of section 506A of the Federal Food, Drug, and Cosmetic Act.

(h) MARKET EXCLUSIVITY FOR NEW BIO-

LOGICAL PRODUCTS.—If, prior to approval of an application that is submitted under subsection (a), the Secretary determines, on the information relating to the use of a new biological product in the pediatric population may produce health benefits in that population, the Secretary shall request for pediatric studies (which shall include a timeframe for completing such studies), the applicant agrees to the request, such studies shall be completed using appropriate formula-

tions for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and ac-

cepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act.

(A) the periods for such biological product referred to in section 526 are deemed to be 4 years and 6 months rather than 4 years and 12 years and 6 months rather than 12 years; and

(B) if the biological product is designated under section 526 for a rare disease or condi-

tion, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years and 12 years.

(4) MARKET EXCLUSIVITY FOR ALREADY-

MARKETED BIOLOGICAL PRODUCTS.—If the Sec-

retary determines that information relating to the use of a licensed biological product in the pediatric population may produce health benefits in that population and makes a written request to the holder of an approved application for pediatric studies (which shall include a timeframe for completing such studies), the holder agrees to the request, such studies are completed using appropriate formula-

tions for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and ac-

cepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act.

(5) USE.—Notwithstanding any other provi-
sion of this Act (or an amendment made by this Act), the savings to the Federal Government attributable to the enactment of this subtitl

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Subtitle B—More Affordable Medicines for Children and Under served Communities

SEC. 6101. EXPANDED PARTICIPATION IN 340B PROGRAM.

(a) Expansion of Covered Entities Receiving Discounted Prices.—Section 340B(b)(1) of the Public Health Service Act (42 U.S.C. 256b(a)(5)) is amended to read as follows:

(5) An entity that is a rural referral center, as defined by section 1861(d)(5)(C)(i) of the Social Security Act, or a sole community hospital, as defined by section 1861(d)(5)(C)(ii) of such Act, and that meets the requirements of subparagraph (L)(i) and has a disproportionate share adjustment percentage equal to or greater than 8 percent;

(b) Extension of Discount to Inpatient Drugs.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(1) in paragraphs (2), (5), (7), and (9) of subsection (a), by striking “outpatient” each place it appears; and

(2) in subsection (b)—

(A) by striking “Other Definition” and all that follows through “In this section” and inserting the following: “Other Definitions.—

(I) In general.—In this section;” and

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

(2) Covered Drug.—In this section, the term ‘covered drug’ means a covered outpatient drug (as defined in section 1927(c)(2) of the Social Security Act); and

(B) includes, notwithstanding paragraph (3)(A) of section 1927(c) of such Act, a drug used in connection with an inpatient or outpatient service provided by a hospital described in subparagraph (L), (M), or (N) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section.”;

(c) Prohibition on Group Purchasing Arrangements.—Section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)) is amended—

(1) in paragraph (4)(L)—

(A) in clause (i), by adding “and” at the end;

(B) in clause (ii), by striking “; and” and inserting a period; and

(C) by redesignating clauses (i) and (ii) as clauses (ii) and (iii), respectively; and

(2) in paragraph (5), as amended by subsection (b)—

(A) by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively; and

(B) by inserting after subparagraph (B), the following:

(2) Prohibition on Group Purchasing Arrangements.—

(I) In general.—A hospital described in subparagraph (L), (M), or (N) of paragraph (4) shall not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement, except as permitted or provided for pursuant to clauses (ii) or (iii) of section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)) and any other circumstances beyond the hospital’s control;

(II) to facilitate generic substitution when a generic covered outpatient drug is available at a lower price;

(III) to reduce in other ways the administrative burden on Secretary and both inventories of drugs subject to this section and inventories of drugs that are not subject to this section, so long as the exceptions do not create a duplicate discount problem in violation of subparagraph (A) or a diversion problem in violation of subparagraph (B).

(iv) Purchasing Arrangements for Inpatient Drugs.—An entity shall ensure that a hospital described in subparagraph (L), (M), or (N) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section shall have multiple options for purchasing covered drugs for inpatients, including by utilizing a group purchasing organization or other group purchasing arrangement, establishing and utilizing its own group purchasing program, purchasing directly from a manufacturer, and any other purchasing arrangements that the Secretary determines is appropriate to ensure access to drug discount pricing under this section for inpatient drugs taking into account the particular needs of small and rural hospitals.”;

(d) Effective Dates.—

(I) In general.—In this section and section 6102 shall take effect on January 1, 2010, and shall apply to drugs purchased on or after January 1, 2010.

(II) Subsection (b) and subsection (c) of section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)), notwithstanding any other provision of law.

SEC. 6102. IMPROVEMENTS TO 340B PROGRAM INTEGRITY.

(a) Integrity Improvements.—Subsection (d) of section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended to read as follows:

(1) Improvements in Program Integrity.—

(A) Manufacturer Compliance.—

(i) In general.—From amounts appropriated under paragraph (4), the Secretary shall fund the costs of compliance with the requirements of this section and section 6102 shall take effect on January 1, 2010, and shall apply to drugs purchased on or after January 1, 2010.

(ii) Improvements.—The improvements described in subparagraph (A) shall include the following:

(I) The development of a system to enable the Secretary to verify the accuracy of ceiling prices calculated by manufacturers under subsection (a)(4) that is enrolled to participate in the drug discount program under this section.

(II) Developing and publishing through an appropriate regulatory or policy issuance, preclearance standards and methodology for the calculation of ceiling prices under this subsection.

(III) Comparing regularly the ceiling prices calculated by the Secretary with the quarterly pricing data that is reported by manufacturers to the Secretary.

(iii) Performing spot checks of sales transactions by covered entities.

(iv) Inquiring into the cause of any pricing discrepancies that may be identified and either taking, or requiring manufacturers to take whatever actions are appropriate in response to such pricing discrepancies.

(III) Establishment of procedures for manufacturers to issue refunds to covered entities that are overcharged by the manufacturers, including the following:

(I) Providing the Secretary with an explanation of why and how the overcharge occurred, how the refunds will be calculated, and to whom the refunds will be issued.

(II) Oversight by the Secretary to ensure that the refunds are issued accurately and within a reasonable period of time, both in routine instances of retroactive adjustment and to reflect unusual circumstances such as erroneous or intentional overcharging for covered drugs.

(III) The provision of accounts through the Internet website of the Department of Health and Human Services to the applicable ceiling prices for covered drugs as calculated by the Secretary and made available to the public in accordance with this section, in a manner (such as through the use of password protection) that limits such access to covered entities and adequately assures security and protection of privileged pricing data from unauthorized re-disclosure.

(iv) The development of a mechanism by which—

(1) rebates and other discounts provided by manufacturers to other purchasers subsequent to the sale of covered drugs to covered entities are reported to the Secretary; and

(II) appropriate credits and refunds are issued to covered entities if such discounts or rebates have the effect of lowering the applicable ceiling price for the relevant quarter for the drugs involved.

(IV) Selective auditing of manufacturers and wholesalers to ensure the integrity of the drug discount program under this section.

(V) The imposition of sanctions in the form of civil monetary penalties, which—

(I) shall be assessed according to standards established in regulations to be promulgated by the Secretary not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act;

(II) shall not exceed $5,000 for each instance of overcharging a covered entity that may have occurred; and

(III) shall apply to any manufacturer with an agreement under this section that knowingly and intentionally charges a covered entity a price for purchase of a drug that exceeds the maximum applicable price under subsection (a)(1).

(B) Covered Entity Compliance.—

(i) In general.—From amounts appropriated under paragraph (4), the Secretary shall fund the costs of compliance with the requirements of this section in order to prevent overcharges and other violations of the discount pricing requirements specified in this section.

(ii) Improvements.—The improvements described in subparagraph (A) shall include the following:

(I) The development of a system to enable the Secretary to verify the accuracy of ceiling prices calculated by manufacturers under subsection (a)(4) that is enrolled to participate in the drug discount program under this section.

(II) Developing and publishing through an appropriate policy or regulatory issuance, preclearance standards and methodology for the calculation of ceiling prices under this subsection.

(III) Comparing regularly the ceiling prices calculated by the Secretary with the quarterly pricing data that is reported by manufacturers to the Secretary.

(iii) Performing spot checks of sales transactions by covered entities.

(iv) Inquiring into the cause of any pricing discrepancies that may be identified and either taking, or requiring manufacturers to take whatever actions are appropriate in response to such pricing discrepancies.

(ii) The establishment of procedures for manufacturers to issue refunds to covered entities that are overcharged by the manufacturers, including the following:

(1) Providing the Secretary with an explanation of why and how the overcharge occurred, how the refunds will be calculated, and to whom the refunds will be issued.

(II) Oversight by the Secretary to ensure that the refunds are issued accurately and within a reasonable period of time, both in routine instances of retroactive adjustment and to reflect unusual circumstances such as erroneous or intentional overcharging for covered drugs.

(III) The provision of accounts through the Internet website of the Department of Health and Human Services to the applicable ceiling prices for covered drugs as calculated by the Secretary and made available to the public in accordance with this section, in a manner (such as through the use of password protection) that limits such access to covered entities and adequately assures security and protection of privileged pricing data from unauthorized re-disclosure.

(IV) The development of a mechanism by which—

(1) rebates and other discounts provided by manufacturers to other purchasers subsequent to the sale of covered drugs to covered entities are reported to the Secretary; and

(II) appropriate credits and refunds are issued to covered entities if such discounts or rebates have the effect of lowering the applicable ceiling price for the relevant quarter for the drugs involved.

(III) Selective auditing of manufacturers and wholesalers to ensure the integrity of the drug discount program under this section.

(V) The imposition of sanctions in the form of civil monetary penalties, which—

(I) shall be assessed according to standards established in regulations to be promulgated by the Secretary not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act;

(II) shall not exceed $5,000 for each instance of overcharging a covered entity that may have occurred; and

(III) shall apply to any manufacturer with an agreement under this section that knowingly and intentionally charges a covered entity a price for purchase of a drug that exceeds the maximum applicable price under subsection (a)(1).

(C) Extending Participation in 340B Program.—

(i) In general.—For purposes of this section and section 6102 shall take effect on January 1, 2010, and shall apply to drugs purchased on or after January 1, 2010.
this section, including the processing of chargebacks for such drugs.

(‘‘V) The imposition of sanctions, in appropriate cases as determined by the Secretary, additional to those specified in subparagraph (A) of subsection (a)(5)(E), to which a covered entity has been subject under subsection (a)(5)(E), through one or more of the following actions:

(II) Where a covered entity knowingly and intentionally violates subsection (a)(5)(B), the covered entity shall be required to pay a monetary penalty to a manufacturer or other person or body responsible for adjudicating claims or claims for damages if, in the judgment of such official or body, consolidation is appropriate and consistent with the goals of fairness and economy of resources; and

(III) Where the Secretary determines a violation of subsection (a)(5)(B) was systematic and egregious as well as knowing and intentional, removing the covered entity from the drug discount program under this section and disqualifying the entity from re-entry into such program for a reasonable period of time to be determined by the Secretary.

(III) Referring matters to appropriate Federal authorities within the Food and Drug Administration for prosecution. Such referring authorities include the Office of Inspector General of the Department of Health and Human Services, or other Federal agencies for consideration of appropriate action under other Federal laws. (42 U.S.C. 300gg-27.)

(3) ADMINISTRATIVE DISPUTE RESOLUTION PROCEDURES.—

(4) AUTHORIZATION OF APPEALS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for fiscal year 2010 and each succeeding fiscal year.

(b) CONFORMING AMENDMENTS.—Section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)) is amended—

(1) in subsection (a), by adding at the end the following: ‘‘Each such agreement shall require that the manufacturer furnish the Secretary with reports, on a quarterly basis, of the price for each covered drug subject to the agreement that, according to the manufacturer, represents the maximum price that covered entities may permissibly be required to pay (referred to in this section as the ‘‘ceiling price’’), and shall require that the manufacturer offer each covered entity covered drugs for purchase at, or below the applicable ceiling price if such drug is made available to any other purchaser at any price.’’; and

(2) in the first sentence of subsection (a)(5)(E), as redesignated by section 601(c), by inserting ‘‘after audit as described in subparagraph (D) and after ‘finds’.’’.

SEC. 6103. GAO STUDY TO MAKE RECOMMENDATIONS ON IMPROVING THE 340B PROGRAM.

(a) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that examines whether those individuals served by the covered entities under the program under section 340B of the Public Health Service Act (42 U.S.C. 256b) (referred to in this section as the ‘340B program’’) are receiving optimal health care services.

(b) RECOMMENDATIONS.—The report under subsection (a) shall include recommendations on the following:

(1) Whether the 340B program should be expanded since it is anticipated that the 47,000,000 individuals who are uninsured as of December 2, 2009

(2) Whether mandatory sales of certain products under the program could hinder patients access to those therapies through any provider.

(3) Whether income from the 340B program is being used by the covered entities under the program to further the program objectives.

SEC. 2838. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 182, strike line 20 and all that follows through line 11 on page 183, and insert the following:

(1) ESTABLISHMENT.—The Secretary shall establish a community health insurance option to offer, through the exchanges established under this title, health

Beginning on page 187, strike line 17 and all that follows through line 8 on page 188, and insert the following:

(6) REIMBURSEMENT RATES.—

(A) RATES ESTABLISHED BY SECRETARY.—

(1) IN GENERAL.—The Secretary shall establish payment rates for the community health insurance option for services and health care providers consistent with this section and may change such payment rates.

(2) INITIAL PAYMENT RATES.—

(4) ADJUSTMENTS.—The Secretary may determine the extent to which Medicare adjustments described in subparagraph (A) of subsection (a)(4) shall be applied with regard to the provisions under subsection (f) of such section and the update under subsection (d)(4) under such section for a year as applied under this subparagraph shall not be less than 1 percent.

(b) ADJUSTMENTS.—The Secretary may adjust payment rates for services otherwise established under the fee schedule under section 1395f of the Social Security Act to be applied without regard to the provisions under subsection (f) of such section and the update under subsection (d)(4) under such section for a year as applied under this subparagraph shall be not less than 1 percent.

(b) ADJUSTMENTS.—The Secretary may adjust payment rates for services otherwise established under the fee schedule under section 1395f of the Social Security Act to be applied without regard to the provisions under subsection (f) of such section and the update under subsection (d)(4) under such section for a year as applied under this subparagraph shall be not less than 1 percent.

(b) ADJUSTMENTS.—The Secretary may adjust payment rates for services otherwise established under the fee schedule under section 1395f of the Social Security Act to be applied without regard to the provisions under subsection (f) of such section and the update under subsection (d)(4) under such section for a year as applied under this subparagraph shall be not less than 1 percent.
the Secretary) shall also be eligible for the increased payment rates under subclause (I).

(ii) SUBSEQUENT PERIODS.—Beginning with the fourth year in which the community health insurance option is offered, and for subsequent years, the Secretary shall continue to use an administrative process to set such rates in order to promote payment accuracy, equitable benefit levels, and access to providers, and to promote affordability and the efficient delivery of medical care. Such rates shall not be set at levels expected to increase overall medical costs under the option beyond what would be expected if the process under subparagraph (A)(ii) and clause (i) of this subparagraph were continued.

(III) ESTABLISHMENT OF A PROVIDER NETWORK.—Health care providers participating under Medicare are participating providers in the community health insurance option unless they opt out in a process established by the Secretary.

(C) ADMINISTRATIVE PROCESS FOR SETTING RATES.—Chapter 5 of title 5, United States Code shall apply to the process for the initial establishment of payment rates under this paragraph but not to the specific methodology for establishing such rates or the calculation of such rates.

(D) CONSTRUCTION.—Nothing in this subheading shall be construed:

(i) as limiting the Secretary’s authority to correct for payments that are excessive or deficient, taking into account the amounts paid for similar health care providers and services in the marketplace;

(ii) as affecting the authority of the Secretary to establish payment rates, including payment to providers for the more efficient delivery of services.

(E) LIMITATION ON REVIEW.—There shall be no administrative or judicial review of a payment rate or methodology established under this paragraph.

SA 2839. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to increase payment rates for similar services and providers under Medicare and the community health insurance option offered under this section.

(F) offers a sufficient choice of providers; and

(G) complies with State laws (if any), except as otherwise provided for in this title, including modified community rating and administrative costs (including claims and administrative costs) using methods in general use by qualified health plans.

(II) EXCEPTIONS.—The Secretary may delay the establishment of payment rates under section 1324(b).

(i) IN GENERAL.—An individual enrolled in a community health insurance option under this section shall be eligible for credits under section 36B of the Internal Revenue Code of 1986 in the same manner as an individual who is enrolled in a qualified health plan.

(ii) NO ADDITIONAL FEDERAL COST.—A requirement by a State under subparagraph (B) that benefits in addition to the essential health benefits described in section 1302(b) are included in the essential health benefits required under subparagraph (A) shall be provided to enrollees of a community health insurance option and not affect the amount of a premium tax credit provided under section 36B of the Internal Revenue Code of 1986 with respect to such plan.

(D) STATE MUST ASSUME COST.—A State shall make payments to or on behalf of an eligible individual to defray the cost of any additional benefits described in subparagraph (B).

(E) ENSURING ACCESS TO ALL SERVICES.—Nothing in this Act shall prohibit an individual enrolled in a community health insurance option under this section from being a qualified health plan.

(F) PROTECTING ACCESS TO END OF LIFE CARE.—A community health insurance option offered under this title shall not prohibit an individual enrolled in a community health insurance option from purchasing a formulary that does not cover all essential health benefits.

(II) EXCEPTIONS.—The Secretary shall establish a payment rate or methodology established by the Secretary shall be at rates negotiated by the Secretary.

(G) complies with State laws (if any), except as otherwise provided for in this title, including modified community rating and administrative costs (including claims and administrative costs) using methods in general use by qualified health plans.

(II) EXCEPTIONS.—The Secretary may delay the establishment of payment rates under section 1324(b).

(i) IN GENERAL.—The Secretary shall provide, in the case of services described in subclause (II) furnished during the first 3 years in which a community health insurance option is offered, for payment rates that are 5 percent greater than the rates established under subparagraph (A).

(ii) SPECIAL RULES.—A pre-existing condition shall not be a bar to enrollment in a community health insurance option, and the Secretary shall provide an administrative process to set such rates in order to promote payment accuracy, to ensure adequate beneficiary access to providers, and to promote affordability and the efficient delivery of medical care.

(III) ESTABLISHMENT OF A PROVIDER NETWORK.—Health care providers participating under Medicare are participating providers in the community health insurance option.
unless they opt out in a process established by the Secretary.

(C) ADMINISTRATIVE PROCESS FOR SETTING RATES.—Chapter 5 of title 5, United States Code governs the process for the initial establishment of payment rates under this paragraph but not to the specific methodology for establishing such rates or the calculation of such rates.

(D) CONSTRUCTION.—Nothing in this subtitle shall be construed—
(i) as limiting the Secretary’s authority to correct for payments that are excessive or deficient, taking into account the amounts paid for similar health care providers and services under other Exchange-participating qualified health plans.
(ii) as affecting the authority of the Secretary to establish payment rates, including payment rates for the more efficient delivery of services.

(E) LIMITATION ON REVIEW.—There shall be no administrative or judicial review of a payment rate or methodology established under this paragraph.

SA 2840. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to provide tax relief for the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 182, strike line 20 and all that follows through line 11 on page 183, and insert the following:

(b) ESTABLISHMENT OF COMMUNITY HEALTH INSURANCE OPTIONS.—
(1) ESTABLISHMENT.—The Secretary shall establish a community health insurance option to offer, through the Exchanges established under this title, health insurance options for services and health care providers consistent with this section and the update under subsection (a)(4) of section 1302 of title X of the Social Security Act.

(SA 2841. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to provide tax relief for the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 187, strike line 17 and all that follows through line 8 on page 188, and insert the following:

(6) REIMBURSEMENT RATES.—
(A) RATES ESTABLISHED BY SECRETARY.—
(i) IN GENERAL.—The Secretary shall establish payment rates for the community health insurance option for services and health care providers consistent with this section and may change such payment rates.
(ii) INITIAL PAYMENT RULES.—
(I) IN GENERAL.—Except as provided in subparagraph (A)(ii) and clause (i) of this subparagraph, the Secretary shall base the payment rates under this section for services and providers described in subparagraph (A) on the payment rates for similar services and providers under parts A and B of Medicare under title XVIII of the Social Security Act.

(E) EXCEPTIONS.—
(aa) PAYMENT RATES FOR PRACTITIONERS SERVICES.—Payment rates for practitioners services established under the fee schedule under section 1848 of the Social Security Act shall be applied without regard to

(SA 2842. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 249, strike lines 3 through 12, and insert the following:

(ii) COVERAGE MUST PROVIDE MINIMUM VALUE AND ESSENTIAL BENEFITS.—Except as provided in clause (iii), an employee shall be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(c)(2)) and—
(I) the plan’s share of the total allowed costs of benefits provided under the plan is at least 60 percent of such costs, or
(II) the plan does not provide coverage for at least the essential health benefits required to be provided by a qualified health plan under section 1302(b) of the Patient Protection and Affordable Care Act.

(SA 2843. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 268, after line 19, insert the following:

SEC. 1403. EMPLOYERS ELIGIBLE FOR CREDIT AND REDUCTIONS IF EMPLOYERS PLAN DOESN’T COVER ESSENTIAL HEALTH BENEFITS.

(a) IN GENERAL.—
(1) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986, as added by section 1401, is amended to read as follows:

(ii) the plan does not provide coverage for at least the essential health benefits required to be provided by a qualified health plan under section 1302(b) of the Patient Protection and Affordable Care Act.”.

(b) SURCHARGE ON HIGH INCOME INDIVIDUALS.—
(1) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

(PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS

“Sec. 59B. Surcharge on high income individuals.

“Sec. 59B. SURCHARGE ON HIGH INCOME INDIVIDUALS.

“(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to 5.4%
SA 2844. Mr. SANDERS (for himself and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1973, line 20, strike all through page 1986, line 3, and insert the following:

SEC. 9001. SURCHARGE ON HIGH INCOME INDIVIDUALS.

(a) In General.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS

Sec. 59B. Surcharge on high income individuals.

Sec. 59B. Surcharge on high income individuals.

(a) General Rule.—In the case of a taxpayer other than a corporation, there is hereby imposed upon any other tax imposed by this subtitle a tax equal to 0.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

(b) Taxpayers Not Making a Joint Return.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting '$500,000' for '$1,000,000'.

(c) Modified Adjusted Gross Income.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

(d) Special Rules.—

(1) Nonresident Alien.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

(2) Citizens and Residents Living Abroad.—The dollar amount in effect under subsection (a) (after the application of subsection (b)) shall be decreased by the excess of—

(A) the amounts excluded from the taxpayer's gross income under section 911, over

(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

(4) Not Treated as Tax Imposed by this Chapter for Certain Purposes.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.

(5) Clerical Amendment.—The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS.

(c) Section 15 Not to Apply.—The amendment made by subsection (a) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(d) Effective Date.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2010.
(C) provide an assurance that the State has enacted the law described in subsection (b)(2).

(2) REQUIREMENTS.—The requirements described in paragraph (1) with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows:

(A) determines title D.

(B) Part II of subtitle D.

(C) Section 1402.


(3) PASS THROUGH OF FUNDING.—With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such credits would be paid to the State for the purposes of implementing the State plan under the waiver. Such amount shall be determined annually by the Secretary, taking into consideration the experiences of other States with respect to participation in an Exchange and credits and reductions provided to residents of the other States, except that the Secretary shall determine such amount on the basis of reasonable estimates until such time as data regarding the experiences of other States become available and if such estimates are determined to be incorrect on the basis of such data, the Secretary shall adjust subsequent payments and terminations of agreements that were based on such estimates.

(4) WAIVER CONSIDERATION AND TRANSPARENCY.—

(A) IN GENERAL.—An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).

(B) REGULATIONS.—Not later than 180 days after the date of enactment of this Act, the Secretary shall promulgate regulations relating to waivers under this section that provide—

(i) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

(ii) a process for the submission of an application that ensures the disclosure of—

(I) the provisions of law that the State involved seeks to waive; and

(II) the specific plans of the State to ensure that the waiver will be in compliance with subsection (a)(2);

(iii) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are burdensome with respect to State compliance;

(iv) a process for providing to the Secretary of periodic reports by the State concerning the implementation of the program under the waiver; and

(v) a process for the periodic evaluation by the Secretary of the program under the waiver.

(C) REPORT.—The Secretary shall annually report on any action taken by the Secretary with respect to applications for waivers under this section.

(5) COORDINATED WAIVER PROCESS.—The Secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under the provisions of this title describing a waiver process applicable under titles XVII, XIX, and XXI of the Social Security Act, and any other Federal programs for the provision of health care items or services. Such process shall permit a State to submit a single application for a waiver under any or all of such provisions.

(6) DEFINITION.—In this section, the term "Secretary" means—

(A) the Secretary of Health and Human Services with respect to waivers relating to the provisions described in subparagraph (A) through (C) of paragraph (2); and

(B) the Secretary of the Treasury with respect to waivers relating to the provisions described in paragraph (2)(D).

(7) GRANTING OF WAIVER.—

(A) IN GENERAL.—The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State—

(i) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable experience with programs created by this Act and the provisions of this Act that would be waived;

(ii) will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;

(iii) will not at least a comparable number of its residents as the provisions of this title would provide; and

(iv) will not increase the Federal deficit.

(B) REQUIREMENT TO ENACT A LAW.—

(A) IN GENERAL.—A law described in this paragraph is a State law that provides for State actions under a waiver under this section, including the implementation of the State plan under subsection (a)(1)(B).

(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) and terminate the authority provided under the waiver with respect to the State.

(C) SCOPE OF WAIVER.—

(i) IN GENERAL.—The Secretary shall determine the scope of a waiver of a requirement described in subsection (a)(2) granted to a State under subsection (a)(2).

(ii) LIMITATION.—The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.

(D) DETERMINATIONS BY SECRETARY.—

(i) TIME FOR DETERMINATION.—The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection.

(ii) EFFECT OF DETERMINATION.—

(A) GRANTING OF WAIVERS.—If the Secretary determines to grant a waiver under subsection (a)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

(B) DENIAL OF WAIVER.—If the Secretary determines a waiver should not be granted under subsection (a)(1), the Secretary shall notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefore.

(E) TERM OF WAIVER.—

(i) IN GENERAL.—No waiver under this section shall apply for a period of longer than 5 years unless the State requests continuation of such waiver and such request is granted by the Secretary under paragraph (2).

(ii) APPROVAL OF REQUEST.—A request under paragraph (1) shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. The Secretary may deny such a request only if the Secretary—

(i) determines that the State plan under the waiver to be continued did not meet the requirements under subsection (b); or

(ii) notifies the State in writing of the requirements under paragraph (1) that the State plan did not meet and provides to the State the information used by the Secretary in making such determination that determines that the State does not have an opportunity to appeal such determination and provide information as to how such requirements were met.

The Secretary shall consider any information provided under subparagraph (C) and reconsider its determination under subparagraph (A). The Secretary shall grant the request if the Secretary determines upon reconsideration that the State plan met such requirements.

SA 2847. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 212, line 18, strike "2017" and insert "2014".

SA 2848. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 214, line 12, insert "", except that the Secretary shall determine such amount on the basis of reasonable estimates until such time as data regarding the experiences of other States become available and if such estimates are determined to be incorrect on the basis of such data, the Secretary shall adjust subsequent payments to correct errors in earlier payments that were based on such estimates" after "States".

SA 2849. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 219, strike lines 12 through 20, and insert:
### SEC. 8A—SURCHARGE ON HIGH INCOME INDIVIDUALS

**PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS**

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**GENERAL RULE.**—In the case of a taxpayer other than a corporation, there is hereby imposed in addition to any other tax imposed by this subtitle a tax equal to 5 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

**GENERAL RULE.**—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting $500,000 for $1,000,000.

**MODIFIED ADJUSTED GROSS INCOME.**—For purposes of this section, the term ‘modified adjusted gross income’ means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)), in the case of an estate or trust, adjusted gross income shall be determined as provided in section 6661(e).

**SPECIAL RULES.**—

1. NONRESIDENT ALIEN. In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed hereunder shall be taken into account under this section.

2. CITIZENS AND RESIDENTS LIVING ABROAD. The dollar amount in effect under subsection (a) (after the application of subsection (b)) shall be decreased by the excess of—

   a. The amount of the tax imposed by this chapter for purposes described in section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)), in the case of a trust all the unexpired terms of which begins on or after January 1, 2011, and whose family income (determined in accordance with section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i))) does not exceed 150 percent of the Federal poverty level, over

   b. The amount of any deductions or exclusions disallowed under section 911(d)(6) with respect to amounts taken into account under section 6661(d)(6).

3. CHARITABLE TRUSTS. —Subsection (a) shall not apply to a trust all the unexpired terms of which begins on or after January 1, 2011, and whose family income (determined in accordance with section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i))) does not exceed 150 percent of the Federal poverty level, over

4. NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES. —(A) The tax imposed under subsection (a) shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.

5. CLEMENIAL AMENDMENT. —(A) The table of parts for subsection A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

   **PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS**

6. PROVISIONS OF TERMINAL DATES. —At the end of title I, add the following:

   **SEC. 8A—REVISION OF EFFECTIVE DATES.**

   **(a) IN GENERAL.**—Notwithstanding any other provision of this Act (or an amendment made by this Act) this Act shall be implemented by substituting “2012” for “2014” in each of the following:

   1. Section 2794 of the Public Health Service Act (as added by section 1001).
   2. Section 1001.
   3. Section 1101.
   4. Section 1002.
   5. Section 1253.
   6. Section 1302.
   7. Section 1311.
   8. Section 1322.
   9. Section 1323.
   10. Section 1322.
   11. Section 1341.
   12. Section 36B of the Internal Revenue Code of 1986 (as added by section 1501).
   13. Section 45R of the Internal Revenue Code of 1986 (as added by section 1241).
   15. Section 4980H of the Internal Revenue Code of 1986 (as added by section 1515).
   16. The provisions of title II including the amendments made by such title.

   **SA 2852.** Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. BAUCUS, Mr. DODD, and Mr. HARKIN to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

   Strike section 2001 and insert the following:

   **SEC. 2001. MEDICAID ELIGIBILITY FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF THE FEDERAL POVERTY LEVEL.**

   **(a) ELIGIBILITY FOR NON-TRADITIONAL INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF THE FEDERAL POVERTY LEVEL.**

   **(1) FULL MEDICAID BENEFITS FOR NON-MEDICAID ELIGIBLE INDIVIDUALS.** —Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)) is amended—

   **(A) adding or “at” the end of subclause (VI);**

   **(B) by adding “or” at the end of subclause (VIII);**

   **(C) by adding at the end the following new subclause: **

   **‘(VIII) who are under 65 years of age, who are not described in a previous subclause of this clause, who are not entitled to hospital insurance benefits under part A of title XVIII, and whose family income (determined using methodologies and procedures specified by the Secretary) does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 6702 of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.’’**

   **(2) MEDICARE COST SHARING ASSISTANCE FOR MEDICARE-ELIGIBLE INDIVIDUALS.** —Section 1902(a)(10)(E) of such Act (42 U.S.C. 1396a(a)(10)(E)) is amended—

   **(A) in clause (iii), by striking “and” at the end;**

   **(B) in clause (iv), by adding “and” at the end; and**

   **(C) by adding at the end the following new clause:**

   **‘‘(v) for making medical assistance available for medicare cost-sharing described in**

   **SA 2851.** Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. BAUCUS, Mr. DODD, and Mr. HARKIN to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

   **SEC. 2851. AMENDMENT OF ELIGIBILITY REQUIREMENTS.**—In the case of a taxpayer other than a corporation, there is hereby imposed in addition to any other tax imposed by this subtitle a tax equal to 5 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.
subparagraphs (B) and (C) of section 1905(p)(3), for individuals under 65 years of age who would be qualified Medicare beneficiar- ies described in section 1905(p)(1) but for the fact that their income exceeds the in- come level established by the State under section 1905(p)(2) but is less than 150 percent of the official poverty line (referred to in this section) for a family of the size in- volved; and”. (3) INCREASED FMAP FOR NON-TRADITIONAL FULL MEDICAID ELIGIBLE INDIVIDUALS.— Section 1902(a)(10)(A)(i) of such Act (42 U.S.C. 1396d) is amended— (A) in the first sentence of subsection (b), by striking “(v)” before “(vi)” and by inser- ting before the period at the end the fol- lowing: “, and (5) 100 percent (for periods be- fore 2015 and 91 percent for periods beginning with 2015) of amounts described in subsection (y)’’; and (B) by adding at the end the following new subsection: “(y) ADDITIONAL EXPENDITURES SUBJECT TO INCREASED FMAP.—For purposes of section 1905(b)(5), the amounts described in this subsection are the following: “(1) amounts expended for medical assist- ance for individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), (b) Nothing in this subsection shall be construed as not providing for coverage under subparagraph (A)(i)(VIII) or (E)(v) of section 1902(a)(10) of the Social Security Act by paragraph (1) and (2), or an increased FMAP under the amend- ments made by paragraph (3), for an indi- vidual who has been provided medical assistance under title XIX of the Act in accordance with a demonstration waiver approved under section 1115 of such Act or with State funds. (5) CONFORMING AMENDMENTS.—Section 1905(b)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)) is amended— (i) by inserting “1902(a)(10)(A)(i)(VIII),” after “1902(a)(10)(A)(i)(VII),’’; and (ii) by inserting “1902(a)(10)(A)(iv)(I),” before “1905(b)(1)”’’. (B) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), is amended, in the matter pre- ceding paragraph (1)— (i) by striking “or” at the end of clause (xii); (ii) by adding “or” at the end of clause (xiii); and (iii) by inserting after clause (xii) the fol- lowing: “(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII),’’. (b) ELIGIBILITY FOR TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS WITH INCOME NOT EXCEEDING 150 PERCENT OF THE FEDERAL POVERTY LEVEL. — (1) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396d(a)(10)(A)(i)), as amended by subsection (a), is amended— (A) by striking “or” at the end of sub- clause (VII); and (B) by adding at the end the following new subclauses: “(IX) who are over 18, and under 65 years of age, who would be eligible for medical assist- ance under the State plan under subclause (I), (IV) (as so far as it relates to subsection (I)(x)(B)), (VI), or (VII) (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) for income, who are in families whose in- come exceeds 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or”. (2) INCREASED FMAP FOR CERTAIN TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.— (A) INCREASED FMAP FOR ADULTS.—Section 1905(y) of such Act (42 U.S.C. 1396d(y)), as added by subsection (a)(2), is amended by inserting “or” after “(I)” in the first sentence. (B) ENHANCED FMAP FOR CHILDREN.—Section 1905(b)(4) of such Act is amended by inser- ting “1902(a)(10)(A)(i)(X), or” after “on the basis of section”’’. (3) CONSTRUCTION.—Nothing in this sub- section shall be construed as not providing for coverage under subsection (IX) or (X) of section 1902(a)(10)(A)(i) of the Social Security Act, as added by paragraph (1), or an in- creased or enhanced FMAP under the amend- ments made by paragraph (2), for an individ- ual who has been provided medical assistance under title XIX of the Act in accordance with a demonstration waiver approved under section 1115 of such Act or with State funds. (4) CONFORMING.—Section 1905(b)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by subsection (a)(4), is amended by inserting “1902(a)(10)(A)(i)(X),” after “1902(a)(10)(A)(i)(X),’’’’. (c) NETWORK ADEQUACY.—Section 1932(a)(2) of such Act (42 U.S.C. 1396l(a)(2)), is amended by adding at the end the following new subclauses: “(D) ENROLLMENT OF NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS WHO ARE ELIGIBLE TO BE COVERED UNDER PARAGRAPH (2) THE ENROLLMENT REQUIREMENT UNDER PARAGRAPH (2) APPLY TO ITEMS AND SERVICES FURNISHED ON OR AFTER JUNE 16, 2009;” (E) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2013, and 67 percent with respect to items and services furnished on or after such date.” (e) DEFINITIONS.—In this section: (1) MEDICAID ELIGIBLE INDIVIDUAL.—The term “Medicaid eligible individual” means an individual who is eligible for medical as- sistance under Medicaid. (2) TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term “traditional Medicaid eligible individual” means a Medicaid eligible individual other than an individual who is— (A) a Medicaid eligible individual by reason of the application of subclause (VIII) of section 1902(a)(10)(A)(i) of the Social Security Act; or (B) a childless adult not described in section 1902(a)(10)(A) or (C) of such Act (as in ef- fect as of the day before the date of the en- actment of this Act.” (3) NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term “non-traditional Med- icaid eligible individual” means a Medicaid eligible individual other than a traditional Medicaid eligible individual. (A) AMOUNTS EXPENDED.—The Secretary shall, as soon as practicable after the date of the enactment of this Act, make such allocations of the amounts described in subsection (y) as he determines are necessary to achieve the purposes of this Act.” (B) CONSTRUCTION.—Nothing in this sub- section shall be construed as not providing for coverage under subparagraph (A)(i)(VIII) or (E)(v) of section 1902(a)(10) of the Social Security Act, as added by paragraphs (1) and
(2), or an increased FMAP under the amendments made by paragraph (3), for an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

5. CONFORMING AMENDMENTS.—

(a) Section 1905(b)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)) is amended—

(i) by inserting “1902(a)(10)(A)(i)(IX),” after “1902(a)(10)(A)(i)(VIII),”; and


(b) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), is amended, in the matter preceding paragraph (1),—

(i) by striking “or” at the end of clause (xii); and

(ii) by adding “or” at the end of clause (xiii); and

(iii) by inserting after clause (xiii) the following:

“(xiv) individuals described in section 1902(a)(10)(A)(ii)(I),” and

(b) ELIGIBILITY FOR TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS WITH INCOME NOT EXCEEDING 150 PERCENT OF THE FEDERAL POVERTY LEVEL.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396b(f)(4)) is amended, as by subsection (a), is amended—

(A) by striking “or” at the end of subclause (VII); and

(B) adding at the end the following new subclauses:

“(X) who are over 18, and under 65 years of age, who would be eligible for medical assistance under the State plan under subclause (I) or section 1931 (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) but for income, who are in families whose income does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or

“(Y) beginning with 2014, who are under 19, years of age, who would be eligible for medical assistance under the State plan under subclause (I) or section 1931 (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) but for income, who are in families whose income does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or”;

(2) INCREASED FMAP FOR CERTAIN TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—

(A) INCREASED FMAP FOR ADULTS.—Section 1905(b)(y) of such Act (42 U.S.C. 1396d(y)), as added by subsection (a)(2)(B), is amended by inserting “or” at the end of “VIII”;

(B) ENHANCED FMAP FOR CHILDREN.—Section 1905(b)(4) of such Act is amended by inserting “1902(a)(10)(A)(i)(X),” after “on the basis of section”.

(3) CONSTRUCTION.—Nothing in this section shall be construed as not providing for coverage under subclause (IX) or (X) of section 1902(a)(10)(A)(i) of the Social Security Act, as added by paragraph (1), or an increased or enhanced FMAP under the amendments made by paragraph (2), for an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

(4) INQUIRY.—Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by subsection (a)(4), is amended—


(b) NETWORK ADEQUACY.—Section 1902(a)(2) of the Social Security Act (42 U.S.C. 1396a-2(a)(2)) is amended by adding at the end the following new subparagraph:

“(D) ENROLLMENT OF NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS. —Such State may not require under paragraph (1) the enrollment in a managed care entity of an individual described in section 1902(a)(10)(A)(i)(VIII) unless the State demonstrates, to the satisfaction of the Secretary, that the entity, through its provider network and other arrangements, has the capability to meet the health, mental health, and substance abuse needs of such individuals.”;

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2013, and shall apply with respect to items and services furnished on or after such date.

(d) DEFINITIONS.—In this section:

(1) MEDICAID ELIGIBLE INDIVIDUAL.—The term “Medicaid eligible individual” means an individual who is eligible for medical assistance under section 1902(a)(10)(A).

(2) TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term “traditional Medicaid eligible individual” means a Medicaid eligible individual other than a non-traditional Medicaid eligible individual.

(E) SECTION 15 NOT TO APPLY.—The amendment made by subsection (a) shall not be treated as a change in a rate for purposes of section 15 of the Internal Revenue Code of 1986.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SA 2854. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 103, line 10, insert before the period the following: “, including oral and vision care”.

SA 2855. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. . ORAL AND VISION CARE.

(a) TECHNICAL AMENDMENT.—Section 1302(b)(1)(A) of this Act is amended by inserting “, including oral and vision care” before the period.

(b) SURCHARGE ON HIGH INCOME INDIVIDUALS.—

(1) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

“PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS

“Sec. 59B. Surcharge on high income individuals.

“SEC. 59B. SURCHARGE ON HIGH INCOME INDIVIDUALS.

(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed a surcharge on high income individuals.

(b) SURCHARGE ON HIGH INCOME INDIVIDUALS.—

(1) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

“PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS

“Sec. 59B. Surcharge on high income individuals.”
(a) *General Rule.—* In the case of a taxpayer other than a corporation, there is hereby imposed a surcharge of 0.9 percent on any tax imposed by this subtitle or section 351(k) of the Public Health Service Act which is subject to a surcharge under section 351(k). In the case of a corporation, there is hereby imposed a surcharge of 0.9 percent on any tax imposed by this subtitle or section 351(k) of the Public Health Service Act which is subject to a surcharge under section 351(k).

(b) *Taxpayers Not Making a Joint Return.—* In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 163(d)), the amount of any tax imposed by this subtitle or section 351(k) of the Public Health Service Act which is subject to a surcharge under section 351(k) shall be determined as provided in section 67(e).

(c) *Modified Adjusted Gross Income.—* For purposes of this section, the term "modified adjusted gross income" means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)), and the following:

1. Basis for Compensation.—In the case of any taxpayer other than a corporation, there is hereby imposed a surcharge of 0.9 percent on any tax imposed by this subtitle or section 351(k) of the Public Health Service Act which is subject to a surcharge under section 351(k).

2. Basis for Compensation.—In the case of a corporation, there is hereby imposed a surcharge of 0.9 percent on any tax imposed by this subtitle or section 351(k) of the Public Health Service Act which is subject to a surcharge under section 351(k).

3. Basis for Compensation.—In the case of any taxpayer other than a corporation, there is hereby imposed a surcharge of 0.9 percent on any tax imposed by this subtitle or section 351(k) of the Public Health Service Act which is subject to a surcharge under section 351(k).

SEC. 2709. APPLICATION OF PREMIUM AND COVERAGE RULES TO GRANDFATHERED GROUP PLANS AND OTHER LARGE GROUP PLANS.

Notwithstanding section 2701 or 2707, or section 1251 of the Patient Protection and Affordable Care Act, in the case of plan years beginning after December 31, 2013, sections 2701 and 2707 shall apply to a group health plan, and a health insurance issuer offering group health insurance coverage, which is—

1. (a) a grandfathered health plan (as defined in section 1251(e) of such Act); or

2. (b) health insurance coverage offered in the large group market.

SA 2857. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 162, after line 25, add the following:

(7) **CAP ON PRIVATE INSURANCE COMPANY EXECUTIVE COMPENSATION.—**

(A) LIMITS ON COMPENSATION FOR EXECUTIVES OF PRIVATE INSURANCE COMPANIES PARTICIPATING IN AN EXCHANGE.—

(i) A health insurance issuer offering coverage through an Exchange shall only receive a payment equal to 5.4 percent of so much of the modified adjusted gross income of an executive employee as exceeds $1,000,000.

(ii) For purposes of paragraph (i), the term "modified adjusted gross income of an executive employee" means the modified adjusted gross income of such employee reduced by any deduction (not taken into account in determining modified adjusted gross income) allowed for investment interest (as defined in section 163(d)) and shall be determined as provided in section 67(e).

 commodity.

SEC. 2701. ETHICAL PATHWAY FOR THE AP- PRAISAL OF GE-NERIC PHARMACEUTICAL PROD- UCTS.

(a) Definitions.—In this section—

(1) the term "new drug application" means an abbreviated application for a new drug submitted under section 505(c)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(c)); and

(2) the term "Commissioner" means the Commissioner of Food and Drugs; and

(b) Ethical Pathway.—As soon as practical after the date of enactment of this Act, the Secretary, acting through the Commissioner, shall establish a mechanism by which the term of an abbreviated new drug application for a new drug submitted under section 505(c)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(c)) referred to in paragraph (1) shall begin to run for all subsequent applications for such new drug submitted under such section 505(c)(2).

(c) Cost-Sharing Arrangement.—The cost-sharing arrangement described in this subsection is an arrangement in which—

(1) the filer of the abbreviated new drug application or the application under section 351(k) of the Public Health Service Act pays a fee to the Commissioner;

(2) notwithstanding any other provision of law, the Commissioner provides such a filer;

(3) such filer may, notwithstanding any provision of chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.), or of the Public Health Service Act (42 U.S.C. 265 et seq.), in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 126, after line 4, add the following:

(7) **CAP ON PRIVATE INSURANCE COMPANY EXECUTIVE COMPENSATION.—**

(A) LIMITS ON COMPENSATION FOR EXECUTIVES OF PRIVATE INSURANCE COMPANIES PARTICIPATING IN AN EXCHANGE.—

(i) A health insurance issuer offering coverage through an Exchange shall only receive a payment equal to 5.4 percent of so much of the modified adjusted gross income of an executive employee as exceeds $1,000,000.

(ii) For purposes of paragraph (i), the term "modified adjusted gross income of an executive employee" means the modified adjusted gross income of such employee reduced by any deduction (not taken into account in determining modified adjusted gross income) allowed for investment interest (as defined in section 163(d)) and shall be determined as provided in section 67(e).

(c) **Cost-Sharing Arrangement.—** The cost-sharing arrangement described in this subsection is an arrangement in which—

(1) the filer of the abbreviated new drug application or the application under section 351(k) of the Public Health Service Act pays a fee to the Commissioner;

(2) notwithstanding any other provision of law, the Commissioner provides such a filer;

(3) such filer may, notwithstanding any provision of chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.), or of the Public Health Service Act (42 U.S.C. 265 et seq.), in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 162, after line 25, add the following:

(7) **CAP ON PRIVATE INSURANCE COMPANY EXECUTIVE COMPENSATION.—**

(A) LIMITS ON COMPENSATION FOR EXECUTIVES OF PRIVATE INSURANCE COMPANIES PARTICIPATING IN AN EXCHANGE.—

(i) A health insurance issuer offering coverage through an Exchange shall only receive a payment equal to 5.4 percent of so much of the modified adjusted gross income of an executive employee as exceeds $1,000,000.

(ii) For purposes of paragraph (i), the term "modified adjusted gross income of an executive employee" means the modified adjusted gross income of such employee reduced by any deduction (not taken into account in determining modified adjusted gross income) allowed for investment interest (as defined in section 163(d)) and shall be determined as provided in section 67(e).

Notice of Hearing

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing will be held on Thursday, December 17, 2009, at 2:30 p.m. in room SD–366 of the Dirksen Senate Office Building.
The purpose of the hearing is to receive testimony on the following bills:
S. 1470, to sustain the economic development and recreational use of the National Forest System land and other public land in the State of Montana, to add certain land to the National Wilderness Preservation System, to release certain wilderness study areas, to designate new areas for recreation, and for other purposes;
S. 1719, to provide for the conveyance of certain parcels of land to the town of Alta, Utah;
S. 1787, to reauthorize the Federal Land Transaction Facilitation Act, and for other purposes;
H.R. 762, to validate final patent number 27-2005-0081, and for other purposes; and
H.R. 934, to convey certain submerged lands to the Commonwealth of the Northern Mariana Islands in order to give that territory the same benefits in its submerged lands as Guam, the Virgin Islands, and American Samoa have in their submerged lands.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the record should send it to the Committee on Energy and Natural Resources, United States Senate, Washington, DC 20510-6150, or by e-mail to allison_seyferth@energy.senate.gov.

For further information, please contact Scott Miller or Allison Seyferth.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry be authorized to meet during the session of the Senate on December 2, 2009, at 9:30 a.m. in room 216 of the Hart Senate Office Building.

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

COMMITTEE ON ARMED SERVICES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on December 2, 2009, at 9:30 a.m. in room 216 of the Hart Senate Office Building.

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

COMMITTEE ON COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet during the session of the Senate on December 2, 2009, at 10 a.m. in room 233 of the Russell Senate Office Building.

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate to conduct a hearing on December 2, 2009, at 10 a.m., in room SD-366 of the Dirksen Senate Office Building.

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

COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS AND THE SUBCOMMITTEE ON SUPERFUND, TOXICS, AND ENVIRONMENTAL HEALTH

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Environment and Public Works and the Subcommittee on Superfund, Toxics, and Environmental Health be authorized to meet during the session of the Senate on December 2, 2009, at 2:30 p.m. in Room 460 of the Dirksen Senate Office Building.

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

COMMITTEE ON THE JUDICIARY

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on December 2, 2009, at 10 a.m. in room SD-236 of the Dirksen Senate Office Building, to conduct a hearing entitled "Has the Supreme Court Limited Americans’ Access to Courts?"

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

AD HOC SUBCOMMITTEE ON DISASTER RECOVERY

Mr. DURBIN. Mr. President, I ask unanimous consent that the Ad Hoc Subcommittee on Disaster Recovery of the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on December 2, 2009, at 2:30 p.m. to conduct a hearing entitled, "Disaster Case Management: Developing a Comprehensive National Program Focused on Outcomes."

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

EXTENDING CONDOLENCES TO SLAIN WASHINGTON OFFICERS’ FAMILIES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 306, submitted earlier today.

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

UNANIMOUS CONSENT AGREEMENT—H.R. 3590

Mr. DURBIN. Mr. President, I ask unanimous consent that the previous order with respect to H.R. 3590 be modified to provide that the time until 11:45 a.m. be equally divided between Senator MIKULSKI and the minority leader or their designees.

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

ORDERS FOR THURSDAY,
DECEMBER 3, 2009

Mr. DURBIN. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:30 a.m. tomorrow, Thursday, December 3; that following the prayer and the pledge, the Journal of
proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 3590, the health care reform legislation, as provided for under the previous order.

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

PROGRAM

Mr. DURBIN. Mr. President, under a previous order, at 11:45 a.m., there will be a series of two rollcall votes and two more votes at 2:40 p.m. Those votes will be in relation to the Mikulski amendment, as amended, the Murkowski amendment, the Bennet of Colorado amendment, and the McCain motion to commit.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. DURBIN. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate adjourn under the previous order.

There being no objection, the Senate, at 8:31 p.m., adjourned until Thursday, December 3, 2009, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF COMMERCE

DAVID W. MILLS, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF COMMERCE, VICE DARRELL W. JACKSON, RESIGNED.

INTERNATIONAL MONETARY FUND

DOUGLAS A. REDKER, OF MASSACHUSETTS, TO BE UNITED STATES ALTERNATE EXECUTIVE DIRECTOR OF THE INTERNATIONAL MONETARY FUND FOR A TERM OF TWO YEARS, VICE DANIEL D. HEATH, TERM EXPIRED.

FEDERAL MARITIME COMMISSION

MICHAEL A. KHOURI, OF KENTUCKY, TO BE A FEDERAL MARITIME COMMISSIONER FOR A TERM EXPIRING JUNE 30, 2011, VICE STEVEN ROBERT BLOOM, RESIGNED.

IN THE COAST GUARD

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES COAST GUARD TO THE GRADE INDICATED UNDER SECTION 271, TITLE 14, U.S.C.:

To be rear admiral

REAR ADM. (LH) JOSEPH R. CASTILLO
REAR ADM. (LH) DANIEL R. MAY
REAR ADM. (LH) ROY A. NASH
REAR ADM. (LH) PETER F. NEPPRINGER

REAR ADM. (LH) CHARLES W. RAY
REAR ADM. (LH) KEITH A. TAYLOR

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE AND AS PERMANENT PROFESSOR AT THE UNITED STATES AIR FORCE ACADEMY, UNDER TITLE 10, U.S.C., SECTIONS 9333(B) AND 9336(A):

To be colonel

JOSEPH E. SANDERS

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be lieutenant colonel

CHINMOY MISHRA

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be major

CHARLES F. KIMBALL

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be major

MINH THU NGOC LE
ROBERT C. POPE

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

MATTHEW S. FLEMMING
EXTENSIONS OF REMARKS

IN HONOR AND RECOGNITION OF SISTER DONNA L. HAWK

HON. DENNIS J. KUCINICH
OF OHIO
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. KUCINICH. Madam Speaker, I rise today in honor and recognition of Sister Donna L. Hawk of Cleveland, Ohio, as she is named the West Side Catholic Center’s Walk in Faith recipient of 2009.

Throughout her life, Sister Donna Hawk has turned her faith into action, uplifting the lives of those living on the streets. Sister Donna has become a nationally-known leader by creating and operating transitional housing for the homeless, especially for women and their children fleeing domestic violence. While working for many years as a volunteer at the West Side Catholic Shelter, Sister Donna developed a special compassion for women, many of whom had young children seeking refuge from abusive situations.

In 1986, without funding, Sister Donna teamed with Sister Loretta Schulte to rally community leaders and developers in order to transform a motel on Cleveland’s west side into Transitional Housing, Inc.—a place of shelter and source of counseling and resources for women and children in need. For more than twenty years, Transitional Housing, Inc. has served as a model for similar programs throughout the nation and across the world.

Madam Speaker, please join me in honor and recognition of Sister Donna L. Hawk, whose faith in action, unwavering belief in the possibility of transformation, and staunch advocacy has given strength and hope to countless women and children.

IN MEMORY OF HOWARD JACOBS

HON. HENRY A. WAXMAN
OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. WAXMAN. Madam Speaker, as the city of West Hollywood gathers to celebrate the life of Howard Jacobs, I am proud to join the community in recognizing his accomplishments and sharing in the sadness that he was taken from us at such a young age.

Howard Jacobs dedicated his life to helping people in need. His work with the West Hollywood City Council, the City’s Disability Advisory Board, the Rent Stabilization Committee and most recently with First 5 LA, demonstrated the depth and breadth of his devotion to every segment of society. Perhaps he will be best remembered for his activism to fight HIV/AIDS discrimination and educate people about prevention, detection and treatment.

Howard experienced many serious health challenges in his life. When he was first diagnosed with HIV/AIDS in 1989, scientific understanding of the disease was still emerging, societal stigma was pervasive and a diagnosis was a death sentence. But Howard always rallied. He helped West Hollywood design model policies to reduce HIV transmission in the gay community. To many he seemed invincible. Even with his passing it is clear that he will continue to serve as an inspiration.

In my career in public service, I have seen so many instances when one person—one vote—one voice can make a world of difference. Howard Jacobs filled that role so many times and in so many ways. We will forever be in his debt for the world of good he brought in the short time he had to give.

A TRIBUTE TO MS. PEGGY E. WHITEHEAD

HON. EDOLPHUS TOWNS
OF NEW YORK
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. TOWNS. Madam Speaker, I rise today in recognition of Ms. Peggy E. Whitehead. Peggy E. Whitehead is originally from Virginia but relocated to New York to start her career after graduating from high school. Ms. Whitehead has worked over two decades as a bacteriologist in the lab of the Howard Johnson Corporation. Upon the closing of the facility, she hit the ground running. Determination has always been a major player in her life. Through the years, she promoted several times to where she is today. She holds the title of Assistant Coordinating Manager in the Ambulatory Care Department (Sub-Specialty) at Queens Hospital, where she is responsible for day to day operations of twenty clinics.

Ms. Whitehead has received the prestigious Ace Award which signifies excellence, leadership and innovation. In addition, she also received the employee of the month award on several occasions. She has been a volunteer for over six years, within the American Cancer Society. She works on many events, from Making Strides, to RELAY FOR LIFE, to helping with health fairs, all of which are so vital to getting information out to the community. The Ronald McDonald House of New Hyde Park, NY has been an ongoing labor of love event for her in the past seven years. She prepares a feast for the families of the children confined to the Snyder Hospital.

She also participates in the annual New York AIDS Walk. New York has the largest AIDS Walk in the world, raising millions of dollars each year. Peggy has volunteered her services for eight years.

Ms. Whitehead worked with pride on the Obama Campaign and traveled to Washington, DC for the historic inauguration. Whether doing work for the Diabetic Walk or coordinating a drive to help the homeless, she goes about each project with relentless vigor and vitality that speaks to who she is.

She has three children—Jerry, Jennifer, and Karen, and seven grandchildren.

Madam Speaker, I urge my colleagues to join me in recognizing Ms. Peggy E. Whitehead.

ESTABLISHMENT OF A DEMONSTRATION PROGRAM ON GAS TURBINES

SPEECH OF
HON. SHEILA JACKSON-LEE
OF TEXAS
IN THE HOUSE OF REPRESENTATIVES
Tuesday, December 1, 2009

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today in support of H.R. 3029, “to establish a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined cycle power generation systems.” I support this bill because energy efficiency is of the utmost concern to our security, our economy and our future.

H.R. 3029 would direct the Secretary of Energy to carry out a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined cycle power generation systems and identify the technologies that will lead to gas turbine combined cycle efficiency of 65 percent. A combined cycle is an attribute of a power producing engine (or plant) that employs more than one thermodynamic cycle. Heat engines, which are still only able to use a portion of the energy their fuel generates (usually less than 50 percent) are a burden on the American consumer who helps support this inefficient system of energy production. The remaining heat (e.g., hot exhaust fumes) from combustion is generally wasted; combining two or more thermodynamic cycles results in improved overall efficiency.

The bill requires that the program support engineering and gas turbine design for utility-scale and megawatt-scale electric power generation. Under the bill, this includes high temperature materials, improved heat transfer capability, manufacturing technology, combustion technology, advanced controls and systems integration, advanced high performance compressor technology, and validation facilities for the testing of components and subsystems. It also requires that the program include technology and field demonstrations, and assess overall combined cycle system performance.

H.R. 3029 sets out specific program goals. In Phase I, the goal is to develop the conceptual design of and demonstrate the technology required for advanced high efficiency gas turbines that can achieve at least 62 percent combined cycle efficiency on a lower heating value basis. In Phase II, the goal is to develop the conceptual design for advanced high efficiency gas turbines that can achieve at least 65 percent combined cycle efficiency.

This “bullet” symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.
The bill requires that the Secretary solicit proposals from industry, universities, and other appropriate parties for activities under the program within 180 days of enactment. The bill requires the Secretary, in selecting proposals, to emphasize the extent to which the proposal will strengthen or increased retention of jobs in the United States and the extent to which the proposal will promote and enhance United States technology leadership. Awards shall be made on a competitive basis with emphasis on technical merit. H.R. 3029 authorizes $65 million for each of fiscal years 2011 through 2014 for carrying out the program.

HONORING END THE SILENCE
HON. GEORGE RADANOVICH
OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. RADANOVICH. Madam Speaker, I rise today to commend and congratulate End the Silence upon being awarded the “Community Health Champions Award.” I invite my colleagues to join me in wishing End the Silence many years of continued success.

IN HONOR OF LAWRENCE HALPRIN
HON. LYNN C. WOOLSEY
OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Ms. WOOLSEY. Madam Speaker, I rise with sadness today to honor a true American icon, landscape architect Lawrence Halprin, who passed away on October 25, 2009, at the age of 93. Mr. Halprin’s legendary work profoundly influenced concepts of landscape design in this country and around the world.

A long-time resident of Kentfield in Marin County, California, Mr. Halprin’s mark on the Bay Area is particularly evident. From the groundbreaking Sea Ranch development on our Sonoma Coast to Ghirardelli Square and George Lucas’ Letterman Digital Arts Center, he designed memorable spaces that create harmony between people and environment.

Nationally, his best known work is the Franklin D. Roosevelt Memorial in Washington, DC, which artfully invokes Roosevelt’s life and work as visitors stroll through a sculptured plaza in a natural setting. Throughout his career, Larry Halprin was adept at revitalizing perceptions of urban areas and involving the community in his public projects.

Mr. Halprin often worked in partnership with his wife, the well-known dancer Anna Halprin. The two met while attending the University of Wisconsin and were married in 1940. While in Wisconsin, they met Frank Lloyd Wright at Taliesin, and his ideas inspired Mr. Halprin to study landscape architecture at Harvard.

Their collaboration was based on a shared vision of crafting interactive, creative experiences that connect with people on a deep level. Halprin also joined Anna’s dance work, most famously in their 1979 “planetary dance” on Mount Tamalpais. The goal was to take back the mountain for people frightened away by the notorious Trailside Killer. The dance is now performed annually in 36 countries.

While serving in the Navy in World War II, Halprin recuperated in San Francisco from a Japanese attack which had destroyed his ship. After the war, the couple relocated to the Bay Area.

Widely recognized as a man whose genius revolutionized landscape architecture, Mr. Halprin also won a number of awards. These included a Presidential Design Award for the FDR Memorial, the University of Virginia Thomas Jefferson Medal in Architecture, and the prestigious National Medal of the Arts. A man of many talents, he was also recognized for his documentary on Salvador Dalí, “Le Pink Grapefruit.”

In addition to his wife, Mr. Halprin is survived by his daughters Dana and Rana and four grandchildren.

Madam Speaker, it is not easy to summarize the scope of Lawrence Halprin’s influence and accomplishments. As we enjoy his urban environments or the spaciousness of Sea Ranch, we can understand how much his vision and creativity have enriched our lives.

HONORING JOHN C. HARRIS WITH THE DISTINGUISHED CITIZEN AWARD
HON. JIM COSTA
OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. COSTA. Madam Speaker, I rise today to pay special tribute to John C. Harris for receiving the Distinguished Citizen Award, in recognition of his strong dedication to the Boy Scouts of America in the San Joaquin Valley. Mr. Harris has hosted the Westside Luncheon at Harris Ranch for nearly twenty years. This casual and friendly fund raising lunch supports the Scouting programs in western Fresno and Kings Counties. The Luncheon has become a model for other Scout Councils to emulate. In fact, the Monterey Bay Area Council borrowed the Harris model and began a similar event in King City years ago. John’s concern for the youth of our area and his love of Scouting have kept his efforts concentrated in the Sequoia Council, and in the growth of the Scouting in the San Joaquin Valley.

John has been involved in the Agriculture and Thoroughbred business all of his life, as he and his family have worked to create one of the nation’s largest Agribusinesses. A diversified family farming operation, this successful business consists of the Harris Ranch Beef Company, Harris Ranch Inn & Restaurant, Harris Feeding Company, Harris Fresh, and the Harris Farms Horse Division. Much has contributed to California’s bountiful agriculture industry and economic well-being, but one significant underlying factor in California’s agricultural success has been the presence of families such as the Harris family.

We are fortunate to have generous and giving individuals like John Harris, who help to make our Valley a better place. John’s commitment to excellence and hard work reflect much of the same values the Boy Scouts embody in their scout oath: to do your best, help other people at all times, and to serve your country. John Harris certainly lives up to these values as is evident in his business success and devotion to serving others in our community.

For all these reasons, it is without a doubt an honor to recognize John Harris today for his leadership in our Valley, as he continues to touch the lives of many people and leave his mark of good will in our community. We are especially thankful today for his service to the Boy Scouts of America in the Central Valley.

CONGRATULATING GIUSEPPE AND CATERINA TIBERI
HON. JOHN A. BOEHNER
OF OHIO
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. BOEHNER. Madam Speaker, it is a pleasure for me to offer my best wishes to the dear mom and dad of Congressman PATRICK J. TIBERI who will be celebrating their golden wedding anniversary on December 8th. Giuseppe and Caterina Tiberi were married in 1959 in Introdacqua, Italy and have now spent 50 years of marriage together.
“Joe” and “Rina” have been outstanding parents, rearing Pat and his two sisters, Ida and Tania. They are also proud grandparents of six wonderful children: Anthony, Alex, Angelina, Cristina, Daniela and Gabriela.

As loving parents and grandparents, they continue to set an amazing example for others to follow. I join with all of the Tiberi family and their many friends in wishing Joe and Rina all the best on this joyous occasion.

RECOGNIZING THE NEW HARRISON TOWNSHIP PUBLIC LIBRARY

HON. CANDICE S. MILLER
OF MICHIGAN
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mrs. MILLER of Michigan. Madam Speaker, it is my honor to acknowledge the recent grand opening celebration of the new Harrison Township Public Library (HTPL) which was held on October 24th, 2009. I had the privilege to attend this special occasion along with other public officials, library staff and community leaders. The HTPL truly is a remarkable story and is a shining example of what can occur when people come together to accomplish a common goal.

The HTPL is an all-volunteer library and operates on a budget from the sales of used books and other promotional items and also the collection of private donations. Not a single dollar of tax-payer money was used to open the new facility.

It took the will power of very dedicated individuals who worked as a team to ensure Harrison Township would no longer be the only municipality in Macomb County without a library. However, the road to complete this project was anything but easy to navigate. The economic challenges were extremely difficult to overcome, and there were many roadblocks along the way. At times it appeared that the dream was all but lost.

In fact, many would have given up on this project. But the community volunteers would not let this dream fade away, and instead rolled up their sleeves and went back to the drawing board to get the job done. Only through hard work and determination was Harrison Township finally able to open the doors on its new library.

Numerous organizations and people helped make this dream come true: The Township offered the space to house the library; Macomb County donated materials and books to stock shelves; partners from the private sector and academia provided other key resources to furnish the library with proper information technology. I certainly want to commend the numerous library volunteers for all the hours they contributed and the personal sacrifices they made to assist with this effort. I too was more than happy to lend a helping hand by donating books obtained through the Library of Congress’ Surplus Book Program.

Now I am pleased to say that the residents of Harrison Township have their own library! Senior citizens now have a place to read the newspaper or check out a book. Students now have a quiet place to do research, finish their homework or use the Internet. There is even a children’s section that has games, toys and books for families to utilize to help their children learn.

I would like to name for the record the key volunteers who made this dream a reality, for without them, this project would have never come to fruition: Marge Swiatkowski, the Director of Library Volunteer Committee, and her husband Jack; we need to also recognize Joyce Bane, John and Carolyn Biscak, Jim and Mary Lou Bilen, Gale Brady, Tracy Champine, Natalie Cruz, Donna Dertinger, Phil and Marsh Devergilio, Julie Dries, Bobbi Gust, Ann Marie Hergott, Tony Hindman, Kathy Hunt, Jane Jones, Althea Lanuzza, Mary Lapiante, Joan Lavey, Katie LeBlanc, Madaline Mannino, Diane Marvoso, Jean McKay, Kathy McRae, Ellen McKee, Jo Mitchell, Nancy Motring, Mary Oberlieslin, Beverly Ortman, Joan Schmidt, Sandy Schwab, Marty Shadel, Stephanie Simon, Thomas Sycko, Chris Heams, Nancy Trompica, Mary Mahoney, Sheri Mathison, Jane Roda and Dee Turowski.

I applaud each of you for your tireless efforts! Your display of leadership and teamwork are something to be emulated throughout the community.

HONORING THE JUILLIARD SCHOOL’S MUSIC ADVANCEMENT PROGRAM

HON. EDOLPHUS TOWNS
OF NEW YORK
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. TOWNS. Madam Speaker, I rise today in recognition of the Music Advancement Program at The Juilliard School.

The Music Advancement Program (MAP) is a Saturday instrument-instruction program that was created in 1990. MAP targets students, ages eight to fourteen, who are underrepresented in the performing arts. The program is designed to help students at the early stage of their musical development on violin, viola, cello, double bass, flute, clarinet, trumpet, trombone, percussion, and piano. MAP has served families by providing education workshops on diverse topics, information about various concert opportunities and a literacy program for younger siblings of MAP students.

MAP has also supported New York City public school music teachers by building upon their work, starting where most school instrumental programs must end, and by motivating students to excel in all of their endeavors.

Through MAP, The Juilliard School has demonstrated its commitment to being a cultural citizen in New York City by reaching out to underrepresented communities and investing in a future arts community that is diverse in its performers, educators, audiences, and patrons. This exemplary program has enriched the lives of countless students, and will continue to present valuable opportunities in the performing arts for underprivileged students in New York City schools.

Madam Speaker, I urge my colleagues to join me in recognizing the Music Advancement Program at The Juilliard School.

HONORING CITY OF GRAND PRAIRIE

HON. KENNY MARCHANT
OF TEXAS
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. MARCHANT. Madam Speaker, I rise today to honor the City of Grand Prairie. The city is celebrating its 100th anniversary, and I would like to take a moment to speak about the history of the city and its great future.

In 1841, the area that is now Grand Prairie began to be settled by people accepting Republic of Texas land grants. In 1861, Alexander MacRae Dechman traded his wagon and oxen for 239.5 acres in what is now downtown Grand Prairie. He filed for a town plat in 1876, and named the town Dechman. That same year Alexander gave a portion of his land to the Texas and Pacific Railroad in exchange for operating a depot. In 1877, the railroad renamed Dechman to Grand Prairie because of its location on the eastern edge of the prairie that stretched into West Texas.

On March 20, 1909 the citizens of Grand Prairie voted to establish a local city government in order to create the civic infrastructure necessary for public safety, growth and prosperity.

In 1909, the City of Grand Prairie had roughly 1,000 citizens. The city’s growth accelerated during and after World War II when its population changed from 1,595 in 1940 to 14,594 in 1950. The population then doubled to 30,936 by 1960. Today the city is home to more than 168,000 citizens. The growth is symbolic of the city’s strength and success over the last hundred years.

Grand Prairie has created a strong infrastructure to ensure continued growth. The city has constructed attractions for both economic development and tourism such as Lone Star Park in 1992, Nokia Theatre in 2001, the Ruthe Jackson Conference Center in 2002, the Uptown Theater, QuikTrip Ballpark and the AirHogs in 2008 and Market Square in 2009.

The city’s success is also demonstrated by its long list of awards. Some recent awards include the Money Magazine 2008 Best Places to Live in USA, Today Newspaper 2008 Readers’ Choice Award—Best Place to Live, the 2008 National Recreation and Parks Association Gold Medal Award for Best parks system in America and named a Playful City USA in both 2008 and 2009.

Under the able leadership of Mayor Charles England, the City Council and City Manager’s Office, Grand Prairie plans to continue growing stronger for their citizens and businesses. In 2010, the city will open a new Lake Rescue Center, Summit Activity Center for senior citizens and Public Safety Headquarters. A city known for being comfortably casual and incredibly friendly, Grand Prairie looks forward to the next 100 years of dreaming big and making it happen.

I am honored to represent the City of Grand Prairie and I ask my colleagues to join me in congratulating the city upon their 100th anniversary.
HONORING ELI WARREN

HON. SAM GRAVES
OF MISSOURI
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. GRAVES. Madam Speaker, I proudly pause to recognize Eli Warren, a very special young man who has exemplified the finest qualities of citizenship and leadership by taking an active part in the Boy Scouts of America, Troop 1179, and in earning the most prestigious award of Eagle Scout.

Eli has been very active with his troop participating in many scout activities. Over the many years Eli has been involved with scouting, he has not only earned numerous merit badges, but also the respect of his family, peers, and community.

Madam Speaker, I proudly ask you to join me in commending Eli Warren for his accomplishments with the Boy Scouts of America and for his efforts forth in achieving the highest distinction of Eagle Scout.

EXPRESSING SUPPORT FOR GREATER AWARENESS OF OVARIAN CANCER

SPEECH OF
HON. MARY JO KILROY
OF OHIO
IN THE HOUSE OF REPRESENTATIVES
Tuesday, December 1, 2009

Ms. KILROY. Mr. Speaker, I rise today in support of H. Res. 727, which supports the goals and ideals of National Ovarian Cancer Awareness Month.

We all know someone who has been diagnosed with cancer and understand the devastating impact that diagnosis can have on the patient and his or her family. Although we have made great strides in recent years in finding new treatments for those afflicted with cancer, ovarian cancer continues to be difficult to diagnose and when discovered in later stages, the survival rate is lower than 45 percent. Ovarian cancer silently spreads because we cannot reliably screen for it and because its symptoms are common with other diseases.

As an original cosponsor of H.R. 1816, the “Ovarian Cancer Biomarker Research Act,” introduced by my friend and colleague Representative BERMAN, I believe we should encourage collaboration between the federal government and institutions conducting invaluable research on biomarkers for use in risk stratification for, and the early detection and screening of, ovarian cancer. These types of initiatives will ensure that the United States remains a leader in medical breakthroughs and innovations.

We must continue to support funding for research into ovarian cancer, so that we may one day find a cure. We also must devote the necessary resources into developing new screening technology for cancers like ovarian cancer which all too often are found late. Equally important, all women and men need to educate themselves about ovarian cancer so that we save our own lives or those of our loved ones.

PERSONAL EXPLANATION

HON. DENNY REHBerg
OF MONTANA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. REHBerg. Madam Speaker, on rollcall number 911, 912, and 913 I was unavoidably detained due to communications from Billings, MT to Washington, DC. Had I been present, I would have voted “nay” on rollcall 911, “yea” on rollcall 912, and “aye” on rollcall 913.

ENERGY AND WATER RESEARCH INTEGRATION ACT

SPEECH OF
HON. SHEILA JACKSON-LEE
OF TEXAS
IN THE HOUSE OF REPRESENTATIVES
Tuesday, December 1, 2009

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise before you today in support of H.R. 3598, “Energy and Water Research Integration Act.” I would like thank my colleague, Rep. BART GORDON, for introducing this important legislation.

I support this legislation because our country faces immense challenges with increased demand on our energy and water resources. It is for that reason that this bill is a critical component of our country’s energy strategy. According to the Department of Energy’s National Energy Technology Laboratory, the thermoelectric power sector accounts for 39 percent of total freshwater withdrawal in the United States, and 3.3 percent of total fresh-water consumption.

Not only do we need vast quantities of water for energy production, but we also need energy to transport and treat water. Water resource problems are intensifying across all regions of the country. As demand for water continues to rise and supplies dwindle, it has become increasingly apparent that the federal government should create a comprehensive strategy for energy-water research and development of new technologies to ensure sustainable water and energy supplies.

This legislation takes the first steps toward tackling these problems by directing the Secretary of Energy, in carrying out energy research, development, and demonstration programs of the Department of Energy (DOE), to: seek to advance energy and energy efficiency technologies and practices that would minimize freshwater withdrawal and consumption, increase water use efficiency, and utilize non-traditional water sources with efforts to improve the quality of that water; consider the effects climate change may have on water supplies and quality for energy generation and fuel production; and improve understanding of the energy required to provide water supplies and the water required to provide reliable energy supplies throughout the United States.

It further requires the Secretary to incorporate specified considerations, including: new advanced cooling technologies for energy generation and fuel production technologies; innovative water reuse, recovery, and treatment in energy generation and fuel production; and reduction of water resource impacts of fossil fuel resource development.

Finally, this bill directs the Secretary, in coordination with other agencies, to establish an Energy-Water Architecture Council to promote and enable improved energy and water resource data collection, reporting, and technological innovation.

This Council would be required to: adopt data collection and communication standards and protocols for the efforts to provide water supplies and the water required to provide reliable energy supplies; make improvements to federal water use data to increase understanding of trends in power plant water use; integrate existing monitoring networks to provide nationally uniform water and energy use and infrastructure data; and conduct an annual technical workshop to facilitate information exchange among experts on technologies that encourage the conservation and efficient use of water energy.

With these first steps, our country will be far better informed about the challenges wrought by increasing demands for water and energy, and so will be better able to face them.

CONGRATULATING KIM JAKOVICS

HON. JOHN P. SARBANES
OF MARYLAND
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. SARBANES. Madam Speaker, I would like to commend Kim Jakovics, a social studies teacher at Annapolis High School in Maryland, for winning the Milken Educator Award. Since 1987, this prestigious award has been given annually to honor teachers who have distinguished themselves in their incredibly important and challenging field. Of the fifty-three teachers across the nation to be awarded this prize, she is the sole recipient from Maryland. Mrs. Jakovics was selected because of the immeasurable impact she has had on her students. Michael Milken, co-founder of the foundation, said of her instruction, “Students’ self-image changed, their aspirations changed. Students were different after that experience.”

For the past six years, Mrs. Jakovics’ dedication to her students has made them feel more confident to aim for loftier goals. She has been effective in leading classrooms full of students at different skill levels and embraced the challenge of teaching diverse groups.

Because of teachers like Mrs. Jakovics, Annapolis High School has experienced a dramatic improvement in student results. For five years the school failed to meet state testing standards. Over the last two years, however, the school has met standards and been removed from Maryland’s troubled schools watch list. The dedication of teachers like Mrs. Jakovics is what makes such a dramatic turnaround possible.

I hope Mrs. Jakovics will inspire other talented individuals to enter the field of teaching. Once again, I congratulate Mrs. Jakovics and wish her the best of luck.
Mr. RADANOVIĆ. Madam Speaker, I rise today to posthumously honor Dolphas Trotter upon being awarded the “Community Health Champions Award” at the 2009 West Fresno Health Care Coalition’s 5th annual “This Is Your Life of Service” luncheon and awards cerem-
yony. This year the ceremony will be held at the Radisson Hotel Conference Center in Fresno on Tuesday, November 3rd.

Dolphas Trotter was born in 1940 in Idaho, Oklahoma. In 1945 the Trotter family moved cross-country and settled in Southwest Fresno, California. Mr. Trotter attended Wash-

ington Union High School where he played football. During his senior year, he participated in the annual Fresno City-County All-Star game, which earned him a football scholarship to College of the Pacific, known today as Universi-
ty of the Pacific. Mr. Trotter graduated in 1962 with a Bachelor’s degree and returned to Fresno and began working for Fresno County Department of Social Services.

Shortly after his return to Fresno, Mr. Trotter was drafted into the United States Army and was honorably discharged in 1969. This expe-

rience affirmed his belief in the value of education and community. When he returned to Fresno from his military service, he began a career in education. The first of many posi-
tions Mr. Trotter held in education was at Franklin Elementary School as a fifth grade teacher. He moved on to teach at Edison High School, where he later became the Vice Prin-
cipal and the first African American principal of the school. Mr. Trotter had a successful career in the Fresno school system, including serving as Principal at Tioga Middle School and Coo-

per Middle School. For a brief time he served as the first African American interim superintendent of the Fresno Unified School District and then served as the Superintendent at New Millennium Charter Schools.

Mr. Trotter was also a firm believer in community service. He sat on many boards and worked with many organizations, including the African American Historical and Cultural Mu-

useum, the Association of California School Administrators, Cedar Vista Hospital Advisory Board, Channel 24 Portrait of Success Board member, National Alliance of Black School Educators, State Center Com-

munity College Foundation and Washington Union School Board. For his service to these organizations Mr. Trotter has received many accolades.

Mr. Trotter and his wife met while working at the Fresno County Department of Social Serv-
ices. They were married in 1972 and raised four children, including two adopted daughters. Mr. Trotter passed away on March 18, 2009. He was a strong advocate and will be remem-
bered for his inspirational role model for the community and community dialogue.

Madam Speaker, I rise today to honor the life of Dolphas Trotter and recognize him upon being awarded the “Community Health Champions Award.” I invite my colleagues to join me in honoring his life and wishing the best for his family.

HR. BILL SHUSTER
OF PENNSYLVANIA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. SHUSTER. Madam Speaker, I rise today to honor and celebrate the Northern Cambria Lady Colts volleyball team for their remarkable season that ended with a Pennsyl-

vania Interscholastic Athletic Association (PIAA) Class A State Championship title.

The Lady Colts, who concluded their season with an impressive 26–1 record, swept the de-

fending champions, Holy Name—25–14, 30–

28, and 25–22 in the championship match on November 14, 2009. The State Champions title capped off an extraordinary season, with the Lady Colts also winning their 100th con-

secutive conference match. Additionally, these young women also posted their sixth consecu-
tive District VI title as the team completed their season without a single conference loss.

Led by Coach Mike Hogan, the new state champs will be graduating four outstanding seniors: Janae Dunchack, Breanna Kochinsky, and cousins Arie & Jess Rocco. However, this year’s Lady Colts will have twenty-two girls returning next season to follow in the footsteps of their leaders.

I am extremely proud of the hard work and dedication that these young women from Northern Cambria have displayed. I would like to extend my most sincere congratulations to the team, the coaching staff, and their fans on a fantastic season. I wish them the best of luck in all of their future endeavors.

HONORING TUCKER CAMPBELL SEISE
HON. SAM GRAVES
OF MISSOURI
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. GRAVES. Madam Speaker, I proudly ask you to join me in commending Tucker Campbell Seise for his accomplishments with the Boy Scouts of America. Tucker has been very active with his troop participating in many scout activities. Over the many years Tucker has been involved with scouting, he has not only earned numerous merit badges, but also the respect of his fam-

ily, peers, and community.

Madam Speaker, I proudly ask you to join me in commending Tucker Campbell Seise for his accomplishments with the Boy Scouts of America and for his efforts put forth in achiev-

ing the highest distinction of Eagle Scout.

PERSONAL EXPLANATION
HON. JIM GERLACH
OF OHIO
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. GERLACH. Madam Speaker, I rise today to honor the life of Tucker Campbell Seise, a young man who has exemplified the finest qualities of citizenship and leader-

ship by taking an active part in the Boy Scouts of America, Troop 1179, and in earning the most prestigious award of Eagle Scout.

Tucker has been very active with his troop participating in many scout activities. Over the many years Tucker has been involved with scouting, he has not only earned numerous merit badges, but also the respect of his fam-

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Madam Speaker, I proudly ask you to join me in commending Tucker Campbell Seise for his accomplishments with the Boy Scouts of America and for his efforts put forth in achiev-

ing the highest distinction of Eagle Scout.
supporters for the project 33 years ago. The reunion laid the groundwork for an upcoming Smithsonian exhibition on The Running Fence that will serve as a tribute to her partnership with Christo on this remarkable collaboration.

Born in Morocco, Jeanne-Claude met Christo, a Bulgarian refugee who shared her birth date, in Paris in 1958. At that time, Christo was wrapping small objects, and they soon began collaborating on wrapping larger outdoor installations which led to the most famous—Paris's Pont Neuf (1975–1985) and Berlin's Reichstag (1971–1995). Many other projects included natural settings such as Surrounded Islands in Biscayne Bay, Florida; Valley Curtain in Rifle, Colorado; The Umbrellas on hillsides in both California and Japan; and The Gates in Central Park, New York.

Sponsorships were never accepted for these and other installations which were financed through sales of plans, models, drawings, photos, and other documents. The works were always a team effort, with the resulting objects signed with the joint name, “Christo and Jeanne-Claude.”

In addition to her husband, Jeanne-Claude is survived by their son, poet Cyril Christo, and a grandson.

Madam Speaker, Christo will be carrying on the couple’s work, and I am sure that memories of Jeanne-Claude’s vibrancy and love will be a comfort to him during this time. Marin and Sonoma residents will remember her as a natural leader and upon graduation he was selected to remain a T-38 instructor and chief flight examiner. Subsequently, Colonel Hoxie was recognized as the distinguished graduate from his pilot instructor training course. In May 1988, Colonel Hoxie converted to the F-15C at the 60th Tactical Fighter Squadron at Eglin Air Force Base, Florida, and was immediately called upon to fly in support of Operation JUST CAUSE in Panama.

During his time at Eglin Air Force Base, Colonel Hoxie attended Squadron Officer School at Maxwell Air Force Base in Montgomery, Alabama, where he was recognized as a top graduate for his academic and military achievement. Also during this tour, Colonel Hoxie deployed in direct support of Operation DESERT SHIELD/DESERT STORM and flew 66 missions helping to consolidate a swift and complete victory for the allied forces.

Colonel Hoxie went on to work in various staff positions including executive officer to the Athletic Department Director at the United States Air Force Academy, executive officer to the Vice Commander Headquarters, Air Combat Command, and Senior Operations Duty Officer at Osan Air Base, Korea. He also commanded the 94th Flying Training Squadron at the Air Force Academy, led as the Deputy Operations Group Commander at the 34th Operations Group, United States Air Force Academy, utilizing his skill as a trainer and mentor, and was the Chief of Homeland Defense and Security at Headquarters, Air Combat Command, Langley Air Force Base, Virginia. Following this assignment, Colonel Hoxie went on to command the 355th Mission Support Group at Davis Monthan Air Force Base, Arizona.

For the past 2 years, Colonel Hoxie has performed with distinction in the Legislative Liaison Directorate. From May 2008 to March 2009, he led the Programs and Legislative Division, ensuring prompt and thorough response to the Congress on policy and personnel issues concerning the United States Air Force. From March 2009 to the present, Colonel Hoxie led the Congressional Inquiry division, providing efficient and thorough response to over 5,000 requests. As the son of a career military man, Colonel Hoxie knows the sacrifices of its brave men and women in uniform. And yet, under the discriminatory law known as Don’t Ask, Don’t Tell, the talents and contributions of our GLBT service members who testify concerning Don’t Ask, Don’t Tell in a Congressional hearing, as well as those who do so and disclose their sexual orientation.

The United States of America prides itself on having the finest military in the world because of the hard work, dedication, and sacrifices of its brave men and women in uniform. And yet, under the discriminatory law known as Don’t Ask, Don’t Tell, the talents and contributions of our GLBT service members continue to be ignored simply because of who they are. As you know, Don’t Ask, Don’t Tell was signed into law in 1993 by former President Bill Clinton as a compromise to allow gay and lesbian service members to serve in the military. To the contrary, Don’t Ask, Don’t Tell compromises the integrity of our troops and kicks them out to boot. For more than fifteen years, Don’t Ask, Don’t Tell has negatively impacted the lives and livelihoods of these military service members and deprived our Armed Forces of their honorable service. This is not only a disservice to them, but to our country as a whole.
Don’t Ask, Don’t Tell hurts our troops, runs counter to the values of our Armed Forces, and threatens our national security. Since the law was implemented in 1994, over 13,500 qualified service members have been lost to Don’t Ask, Don’t Tell, and counting. With each passing day, we lose approximately two service members. This legislation is misguided, unjust, and debilitating policy. Furthermore, Don’t Ask, Don’t Tell continues to undermine and demoralize the more than 65,000 GLBT Americans currently serving on active duty.

Keeping good troops is good policy, and our GLBT service members are our most talented and dedicated. As the United States continues to work toward responsibly ending the war in Iraq and reengages the threat from al Qaeda in Afghanistan, our GLBT service members offer invaluable skills that enhance our military’s potency and readiness. They are linguists, aviators, medics, and highly trained soldiers who are involved in valuable operations that have nothing to do with their sexual orientation and everything to do with protecting our freedom and advancing our national security interests. Above all, however, they offer their lives to serve their country.

I am extremely proud of the men and women who serve in our Armed Forces and truly appreciate the countless sacrifices they continue to make every single day to protect this nation and the American people. They deserve better than Don’t Ask, Don’t Tell. In order for Congress to have an honest and open discussion about the relevance of the current law, as well as how to best implement its repeal, its members must hear from those about whom Don’t Ask, Don’t Tell was considered controversial, but it should not be. Congress must hear from civilians, GLBT service members currently serving on active duty, GLBT troops are among our most talented and valuable assets. In Afghanistan, our GLBT service members offer invaluable skills that enhance our military’s potency and readiness. They are linguists, medics, and highly trained soldiers who are involved in valuable operations that have nothing to do with their sexual orientation and everything to do with protecting our freedom and advancing our national security interests.

As Congress prepares to debate the future of Don’t Ask, Don’t Tell with hearings in the Senate and in the House of Representatives, we must ensure that we hear all sides of the issue and especially from active-duty GLBT service members. The Honest and Open Testimony Act helps achieve this by addressing a major barrier to an inclusive, transparent, and complete process—fear of retribution for testifying honestly and openly about the consequences of Don’t Ask, Don’t Tell in the Armed Forces. I urge my colleagues to support this important bill, which would bring us one step closer to repealing Don’t Ask, Don’t Tell once and for all and replacing it with a policy of inclusion and non-discrimination.

INTRODUCING THE END DISCRIMINATORY STATE TAXES FOR AUTOMOBILE RENTERS ACT OF 2009

HON. RICK BOUCHER
OF VIRGINIA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. BOUCHER. Madam Speaker, I rise today to introduce the End Discriminatory State Taxes for Automobile Renters Act. I am pleased to be joined by my colleague from Missouri, Todd Akin, as the lead Republican cosponsor of the legislation. Our legislation addresses a situation that most of our constituents have faced at least once and perhaps several times. An individual rents a car from a car rental company and is told the daily rate will be about $25.00. At the end of the rental, the charges from the car rental company are closer to $35.00 or $40.00 per day. Questions inevitably arise about the source of these additional charges.

A small portion of the difference between the car rental company’s daily rate and the amount charged is state or local sales taxes, which consumers pay on most goods and services they purchase. Increasingly, however, the bulk of these additional charges are state and local discriminatory excise taxes on car rental consumers—local taxes imposed to build sport stadiums, convention centers, etc. No matter what the size or scope of a local project, states or localities have sought to “export” the burden of funding these local initiatives by taxing “out-of-town” visitors renting cars in their state, city, or county.

These discriminatory excise taxes on travelers have become increasingly popular in recent years. In 1976, there was one such tax. Since 1990, more than 115 special rental car taxes have been enacted in 43 states and the District of Columbia. As a result, car rental customers have paid more than $7.5 billion in special taxes to fund projects with no direct connection to renting a car. In addition, states, stadiaums, car rental customers are also footing the bill for performing arts centers and a culinary institute. A recent study found that the taxes fall disproportionately on minority households; the taxes raise auto insurance costs; and these taxes reduce purchases of cars by rental companies—an increase of 10% in tax relative to the base rental rate reduces rental demand, and, therefore, purchases of new cars by rental car companies, by approximately 12%.

The End Discriminatory State Taxes for Automobile Renters Act would impose a permanent moratorium on discriminatory excise taxes on car rental customers by declaring these taxes an undue burden on interstate commerce. In the past, Congress has enacted similar protections from discriminatory state and local excise taxes for other interstate travelers such as airlines, train, and bus passengers, and for the property of interstate transportation industries such as the airlines, buses, trains, and motor freight. Our measure would extend this protection to car rental consumers.

The legislation’s moratorium is prospective only. The bill “grandfathers” existing car rental excise taxes to prevent a cut-off of funding for projects financed through these taxes that are already underway, as long as the state or local authorization for these existing taxes does not expire or governments do not try to increase the rate of the tax. And the bill would not in any way restrict the ability of local governments to enact non-discriminatory, general taxes such as sales and income taxes.

Our legislation has been endorsed by a wide range of stakeholders, including the National Consumers League, UAW, and the Big Three automobile manufacturers. I hope my colleagues will join with us in enacting into law the End Discriminatory State Taxes for Automobile Renters Act of 2009.

A TRIBUTE TO THE LIFE OF MRS. NETTIE DURANT DICKSON

HON. JOHN M. SPRATT, JR.
OF SOUTH CAROLINA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. SPRATT. Madam Speaker, I would like to call the attention of the House to the death of a remarkable woman. On November 29, Mrs. Nettie DuRant Dickson of Darlington, South Carolina, died at the age of 106. Remarkable not only for her age, but for a life full of
of accomplishment, Mrs. Dickson and her late husband, William James Dickson, owned the Darlington Hardware. Mrs. Dickson was a member of the Darlington Presbyterian Church and active for years with the American Legion Auxiliary. In the past few years she resided at the Manor Manor in Florence, South Carolina and then at Agape Senior Care in Irmo, South Carolina.

One of twelve children, Nettie DuRant Dickson is survived by her husband, William James Dickson, daughters Elizabeth Betty DuPre and Jeanette D. Renfrow, numerous nieces and nephews, four grandsons and three great-grandsons.

In the end, what counts most is not how long we lived, but how well. On both counts, Nettie DuRant Dickson lived a good and fruitful life.

CONGRATULATING BRIAN KLOCK

HON. PETE OLSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. OLSON. Madam Speaker, I rise today to congratulate a great public servant upon his retirement from the United States Navy—a man who has served his country diligently, my friend Brian Klock.

After 28 years of service to his country, Brian retired from his post as a Commander in the Navy on July 1, 2009. Throughout his career he served as an intelligence officer working as an analyst, an aviation intelligence officer in a P3 Squadron, and as a Naval Criminal Investigative Service (NCIS) Agent. On many occasions his service took him overseas, including during the Cold War and the Bosnian conflict.

After September 11, 2001, Brian was called to serve in NCIS and was assigned to counter intelligence operations overseas. Upon his return to the United States, Brian was asked to join the Protective Services Division. It was here that he spent two years protecting the leadership of the Department of Defense and visiting foreign military dignitaries. At the conclusion of his career, Brian was serving as the operations officer for a CENTCOM intelligence unit.

It is with great pleasure that I congratulate Brian for his years of exemplary service to our nation. I wish him the best in his years to come and hope he lives life to the fullest during his retirement years.

EMERGENCY MEDICINE AND MEDICAL MALPRACTICE REFORM

HON. BART GORDON

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. GORDON of Tennessee. Madam Speaker, as we debate and move forward on this historic endeavor—passage of health care reform with a goal of improving access and coverage for the millions of uninsured and underinsured individuals—I would like to take a moment to discuss the role of emergency medicine and review the various provisions in this bill which strengthen access to emergency care. As we work to improve coverage and enhance preventive and chronic care, we must remember to balance the acute care needs of patients, especially those treated in emergency departments.

Emergency medicine is an essential part of our safety net and must be supported. Whether it be a patient in the emergency room as the result of a suspected H1N1 influenza case, trauma, a natural or manmade disaster, or because they’ve lost their job and health insurance, and a health condition escalates to the point of needing to seek emergency care, we all rely on quality emergency care to be there when we need it. Emergency medicine demands it—unlike other doctors who can choose not to participate with various health insurance plans, Medicare or Medicaid, emergency physicians are required by federal law to treat every patient who walks through the door, regardless of their ability to pay. But, our emergency medical system is in crisis, and the severe problems facing emergency patients affect everyone.

Earlier this year, the American College of Emergency Physicians (ACEP) released its annual report card on emergency care. The nation was graded a C minus overall, with 90 percent of states earning mediocre or failing grades. America earned a near-failing D minus grade in the “Access to Emergency Care” category. This is unacceptable and also terrifying news for the more than 300,000 people each day who need emergency care.

Although my own state of Tennessee outperformed most states in some areas, we have a long way to go. The report states that Tennessee has only 8.9 emergency physicians per 100,000 people and needs an additional 60.2 full-time equivalent mental health care providers to serve the state’s population. Also, it points out that these issues may contribute to hospital crowding and patient transfers, problems that have been identified as priorities among emergency physicians in Tennessee. Further, Tennessee has serious public health and injury prevention challenges. We have among the highest rates of infant mortality in the nation (8.9 deaths per 1,000 births), as well as high percentages of obese adults (28.8 percent) and adults who smoke (22.6 percent). We also have relatively high fatal injury rates: 22.7 homicides and suicides per 100,000 people and 2.2 deaths due to unintentional fire and burn-related injuries per 100,000.

Although the “Affordable Health Care for America Act” included provisions to improve coverage for preventive and chronic care, statistics like these for Tennessee demonstrate that access to quality emergency care will always be a priority and should not be taken for granted.

The health care reform bill passed by the House on November 7 included a number of provisions that would strengthen emergency care in the United States:

Required Coverage for Emergency Services. Specifically, it would require that emergency services be a part of any essential benefits package for all eligible health insurance plans.

Emergency Care Coordination Center. Section 2552 would establish an Emergency Care Coordination Center. The Center will promote and fund research into emergency medicine and trauma health care, promote regional partnerships and more effective emergency medical systems in order to enhance appropriate triage, distribution, and care of routine community patients; and promote local, regional, and State emergency medical systems’ preparedness for and response to public health events. It would also authorize a Council of Emergency Medicine.

Pilot Programs to Improve Emergency Medical Care. Section 2553 would establish demonstration programs that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care systems.

Demonstration Project for Stabilization of Emergency Medical Conditions by Institutions for Mental Diseases. Section 1787 would establish a demonstration project to reimburse psychiatric hospitals that provide required medical assistance to stabilize an emergency medical condition for individuals enrolled in Medicaid.

Hopefully the emergency medicine provisions will be further strengthened as they move through the legislative process to include 198,000 staffed beds between 1993 and 2003. As a result, fewer beds are available to accommodate admissions from the emergency department.

Ambulances are diverted, on average, once a week across the United States. This means the closest emergency department because they are so crowded they cannot handle any more patients. For patients with life-threatening illnesses or injuries, those minutes can make the difference between life and death.

Last year, the American College of Emergency Physicians released a report by its Task Force on Boarding titled, “Emergency Department Crowding: High-Impact Solutions.” ACEP established the task force to develop low-cost or no-cost solutions to boarding. The report is intended to help emergency physicians stop boarding in their own hospitals and ultimately improve patient care. The report identifies those strategies to reduce boarding that have a “high impact,” as well as those that have not proven effective. The report identifies the boarding of admitted patients as the main cause of emergency department crowding.

The report outlines the impact of boarding on patient care stating that “evidence-based research demonstrates that boarding results in the following: delays in care, ambulance diversion, increased hospital lengths of stay, medical errors, increased patient mortality, financial losses to hospital and physician, and medical negligence claims.”
Madam Speaker, to ensure our access to emergency care is protected, we must address this issue. I believe the provisions in my bill, H.R. 1188, “Access to Emergency Medical Services Act,” will help by developing emergency department boarding and ambulance diversion standards and quality measures. I urge their consideration as the bill moves forward through the legislative process.

Emergency care is the most overlooked part of the health care system. But it is the number one service that everyone depends on in their hour of need. It needs our attention now.

In addition to think forward to ensure that our system also accommodates future needs. To do so, we must address the shortage of board-certified emergency physicians. The Society for Academic Emergency Medicine, in 2008, published an Assessment of Emergency Physician Workforce Needs in the United States. The authors reviewed 2005 data and found that the supply of emergency medicine residency-trained, board-certified emergency physicians will not meet future demand. Specifically, they found that only 55% of the demand in the emergency medical board-certified physicians currently is met.

I agree with the need to enhance our prevention efforts and have introduced H.R. 3851, the “Physical Activity Guidelines for Americans Act” to help educate Americans of all ages regarding the need for physical activity, taking responsibility for one’s health and staying fit. However, experience shows that not everyone will adhere to recommended guidelines, and genetic predisposition, trauma and seasonal flu or other illnesses such as H1N1 will continue to bring people to our nation’s emergency rooms. Therefore, we must be sure emergency departments are equipped to handle our needs.

In June 2006, the Institute of Medicine (IOM) released three landmark reports on the “Future of Emergency Care in the United States Health System,” detailing the challenges and concerns this nation faces in maintaining access to emergency medical services. The IOM reported that the nation’s emergency medical system as a whole is overburdened, underfunded and highly fragmented.

Emergency care has long been overlooked and as a result it is stretched to a breaking point. As Congress focuses on health reform this year, I urge my colleagues to recognize the role emergency medicine plays in our safety net and support the provisions in the health reform bill that strengthen emergency care. Further, I urge my colleagues to work to adequately support our emergency medical system by further addressing boarding and diversion as the bill moves forward.

IN APPRECIATION OF SAN BRUNO
MAYOR LARRY FRANZELLA
HON. JACKIE SPEIER
OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Ms. SPEIER. Madam Speaker, this week the City of San Bruno will see a changing of the guard as Mayor Larry Franzella steps down from his role and the new mayor, A. Scott Fitzgerald, begins his career.

A native of San Francisco, Mayor Franzella moved to San Bruno as a boy and attended local schools, including Crestmoor High School, Skyline College and the College of San Mateo. He’s a classic example of “local boy makes good.” He began a successful real estate career in 1975 and over three decades has risen through the ranks of his profession, serving as President of the San Bruno Chamber of Commerce, the Rotary Club of San Bruno, the Peninsula Medical Center, San Bruno City Council, San Bruno Unified School District Board of Trustees, the Peninsula Press Club, Peninsula Medical Center Foundation, the Peninsula-round, the San Bruno Chamber of Commerce, the Rotary Club of San Bruno, the Peninsula Medical Center, San Bruno City Council, San Bruno Unified School District Board of Trustees, the Peninsula Press Club, Peninsula Medical Center Foundation, the Peninsula Medical Center, the Peninsula Medical Center Roundtable, the Peninsula Medical Center Foundation.

Life in San Bruno is very special because Mayor Larry Franzella serves as a champion for our community. We are all better for his more than two decades of dedicated service to San Bruno.

A graduate of San Bruno High School, Mayor Franzella retired from the Chamber of Commerce in 1998 and the San Bruno Roundtable in 2004. He is a devoted family man and proud San Bruno High School alum. Mayor Franzella is a wonderful example of what it means to be a leader in this community.

On November 28, 2009, Mayor Larry Franzella retired from his role as Mayor of San Bruno. He is a dedicated public servant who has served his community with distinction and a commitment to excellence.

In appreciation of Mayor Larry Franzella, a true leader and champion for the people of San Bruno, I rise today to recognize his many years of service and to wish him all the best in his retirement.

IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. CUMMINGS. Madam Speaker, I rise today along with my esteemed colleague from California, Barbara Lee, in order to congratulate Herman and Marjorie Williams of Baltimore, Maryland, as they celebrate sixty years of marriage. Since they exchanged their vows on November 24, 1949, these high school sweethearts have been extraordinary parents, friends, and members of their community.

Over the decades of their marriage, they contended against racism and segregation as they pursued their careers. Herman as one of the first black firefighters in Baltimore and Marjorie at Westinghouse. Their commitment to hard work and to their family never wavered.

Herman eventually became the nation’s first African-American major-city fire chief and Marjorie retired after a long and exemplary career. Even after her retirement, Marjorie has volunteered her time with many charitable organizations, dedicating herself to helping the less fortunate. Always an adventurous spirit, she has also continued to pursue her love of travel.

The two of them together raised four wonderful and successful children: Marjorie, Clotilde, Montel, and Herman. Marjorie and Herman have a fierce dedication to their family, and the values they instilled led their children to prominent careers in the arts, education, civil service, and broadcast media.

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SPECIAL OLYMPICS MASSACHUSETTS AND MR. DON DOWD

HON. PATRICK J. KENNEDY
OF RHODE ISLAND
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. KENNEDY. Madam Speaker, today I rise to commend Special Olympics, Massachusetts and longtime friend Donald J. Dowd. Both Special Olympics, Massachusetts and Mr. Dowd have played key roles in New England and wonderful contributors to the people and culture of our region.

As my colleagues know, Special Olympics provides year-round sports training, athletic competition and other related programming for athletes with intellectual disabilities. This organization founded by my Aunt Eunice Kennedy Shriver in 1968, contributes to the physical, social, and psychological development of people with intellectual disabilities. It is a global force for change with over 2.5 million athletes participating worldwide representing over 140 countries.

In Massachusetts and Rhode Island, Special Olympics does amazing things for the people of New England. Special Olympics Massachusetts also offers Unified Sports, an initiative that combines approximately equal numbers of Special Olympics athletes and athletes without intellectual disabilities, called Partners, on sports teams for training and competition.

One of Special Olympics’ greatest supporters has been Donald Dowd. Mr. Dowd volunteered for my Father in the Other Body for over 40 years, as well as for my uncles. He was responsible for coordinating the opening of the John F. Kennedy Presidential Library and has served as a member of the John F. Kennedy Library Foundation Board since its inception, helping to found the Friends of the Kennedy Library.

He is a lifelong resident of Springfield, Massachusetts, began his career in public service as President Kennedy’s Assistant Regional Director of the U.S. Postal Service for the six New England States, and was a political advisor to U.S. Senator Robert F. Kennedy. I am proud to call him a friend and thank him for his dedication to my family, to Special Olympics, to our region and to our country.

PERSONAL EXPLANATION

HON. NEIL ABERCROMBIE
OF HAWAII
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. ABERCROMBIE. Madam Speaker, I regret that I missed roll call vote No. 902–904 and vote No. 911–913. Had I been present, I would have voted “yea” on all roll call votes.

HONORING WORLD AIDS AWARENESS DAY

HON. CHARLES B. RANGEL
OF NEW YORK
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. RANGEL. Madam Speaker, I rise today to recognize World AIDS Awareness Day. This awareness initiative started on December 1, 1988 with the purpose of raising money, increasing awareness, fighting prejudice, and improving education on HIV/AIDS topics. The World AIDS Day theme for 2009 is “Universal Access and Human Rights,” serving as an important reminder that HIV/AIDS has not gone away, and that there are many things still to be done.

According to the United Nations Joint Programme on HIV/AIDS, there are 33.4 million cases of HIV/AIDS worldwide. Approximately 1.1 million of these cases are in the United States, according to the Centers for Disease Control and Prevention, and there are more than 50,000 new HIV/AIDS infections reported each year in America. Sadly, minority communities face the brunt of its reach. African American are the most affected, representing half of the total 1.1 million cases in the United States. Blacks are 8 times more likely to have AIDS than their White counterparts. The racial disparities are clear, with HIV being the main cause of death for both Black men and women between the ages of 25 to 44. It is of utmost importance that we take action and stand together to stop this pandemic from spreading further.

Congress has played its part in trying to stop the HIV/AIDS epidemic. I applaud the House for passing the Ryan White HIV/AIDS Treatment Extension Act. The Ryan White program has been serving people with AIDS and HIV for nearly two decades. It provides care, treatment, and support services to nearly half a million people—most of whom are low-income. This bill increases the authorization level for each part of the Ryan White program by 5 percent a year for the next four years, making important investments in care and treatment services to ensure the highest quality of life for HIV/AIDS patients, while also funding prevention and outreach programs. I have myself introduced H.R. 1964, The National Black Clergy for the Elimination of HIV/AIDS Act of 2009, which seeks funds for the prevention, testing, education, treatment and care of HIV/AIDS.

Although great efforts have been made to fight HIV/AIDS, much is left to be done by both, the government and citizens. World AIDS Awareness Day is about prevention, education, and increasing awareness of this pandemic that is affecting millions around the globe. This day will bring to many the education on HIV/AIDS topics. The increasing awareness, fighting prejudice, and providing year-round sports training, athletic competition and other related programming for athletes with intellectual disabilities.

This organization founded by my Aunt Eunice Kennedy Shriver in 1968, contributes to the physical, social, and psychological development of people with intellectual disabilities. It is a global force for change with over 2.5 million athletes participating worldwide representing over 140 countries.

In Massachusetts and Rhode Island, Special Olympics does amazing things for the people of New England. Special Olympics Massachusetts also offers Unified Sports, an initiative that combines approximately equal numbers of Special Olympics athletes and athletes without intellectual disabilities, called Partners, on sports teams for training and competition.

One of Special Olympics’ greatest supporters has been Donald Dowd. Mr. Dowd volunteered for my Father in the Other Body for over 40 years, as well as for my uncles. He was responsible for coordinating the opening of the John F. Kennedy Presidential Library and has served as a member of the John F. Kennedy Library Foundation Board since its inception, helping to found the Friends of the Kennedy Library.

He is a lifelong resident of Springfield, Massachusetts, began his career in public service as President Kennedy’s Assistant Regional Director of the U.S. Postal Service for the six New England States, and was a political advisor to U.S. Senator Robert F. Kennedy. I am proud to call him a friend and thank him for his dedication to my family, to Special Olympics, to our region and to our country.

PERSONAL EXPLANATION

HON. NEIL ABERCROMBIE
OF HAWAII
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. ABERCROMBIE. Madam Speaker, I regret that I missed roll call vote No. 902–904 and vote No. 911–913. Had I been present, I would have voted “yea” on all roll call votes.

HONORING THE RESOLVE AND TEAMWORK OF THE NORTH BRANCH HIGH SCHOOL VARSITY GIRLS VOLLEYBALL TEAM

HON. CANDICE S. MILLER
OF MICHIGAN
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mrs. MILLER of Michigan. Madam Speaker, I rise today to acknowledge the hard work, determination and teamwork displayed by the 2009 North Branch Girls Volleyball Team. These young women endured a grueling 83 match season and in the end came out on top as the Class B Michigan State Champions! They collected an impressive overall record of 76–5–2. This was a historic accomplishment because it was the first sports title ever in the school’s history.

Coach Jim Fish did a tremendous job leading the team and bringing them together as a well-coordinated unit to accomplish a common goal—winning a state title. I commend all the assistant coaches, support staff, teachers, parents and fans in the community for their help and making this a season to remember.

However, the road to victory was not easy. The Lady Broncos outlasted the Cadillac Team. The Lady Broncos proved their tenacity and resilience as they beat Cadillac in four hard fought sets. Next North Branch was matched up against Detroit and unfortunately for Kellogg, it just was not in the cards for them to win on this Saturday because destiny was on the side of the Lady Broncos. There was nothing Kellogg could do on the court to prevent North Branch from raising the championship trophy in glorious triumph. The Lady Broncos were determined to finish what they had started since the first practice of the season. And through all the sweat, injuries and difficult training sessions, the Lady Broncos saw their dreams come to fruition as they were awarded the Michigan Volleyball Class B State Champs!

Teamwork, dedication and friendship all helped deliver this first-ever championship in the schools sports history. The entire North Branch community and Lapeer County should take pride in what these young women accomplished.

I certainly share that pride and want to offer my congratulations to everyone who contributed to this team effort. First starting with thex players—Kara Stuewer and Jordan Fish and team members—Katie Smillie, Danika Racknor, Taylor Wiegele, Layne Molosky, Samantha Garza, Hailey Smillie, Catherine Brusie, Laura Johnson, Macaela Deshefsky, Shanel Johnstone, Katie Owens, Stephanie Marsh, and Angela Roth—are all should be extremely proud of this achievement.

In addition, I must mention that not only were these young women champions on the court but in the classroom as well. The volleyball team compiled an outstanding 3.49 GPA and achieved an all-state academic recognition.

My hat also goes off to Head Coach Jim Fish—Assistant Coaches Curt June, Chris
A TRIBUTE TO REGINA MAINOR

HON. ROBERT A. BRADY
OF PENNSYLVANIA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. BRADY. Madam Speaker, I rise today to honor Regina Mainor. For years, Ms. Mainor has served people of Philadelphia as the Director of North Central Victim Services. In December she will celebrate her retirement after many years of service to her community.

Regina Mainor was a hard worker from the beginning, obtaining her Bachelors Degree in Business Education and Masters Degree in Social Work from Temple University. Ms. Mainor obtained a position as Director of North Central Victims Services in 1999, and becoming Executive Director of the agency in 2002. The National Crime Victimization Services (NCVS) is a neighborhood victim service agency which specializes in working with victims of all ages, especially seniors. The NCVS provides crime victims compensation, crisis response, education, counseling, criminal justice/legal advocacy, court accompaniment, case management, and legal services, all of which are free of charge. Ms. Mainor helped the NCVS to get recognized as a federal non-profit organization in 2002.

Ms. Mainor has been recognized by the NAACP with the NAACP Award for Community Service, and she was honored again in 2006 for the National Crime Victims Services Award for Professional Innovation in Victims Services.

Regina Mainor’s long and impressive career showcases her commitment and service to her community. Her contributions to the area of Victim Services will be felt for many years to come. Madam Speaker, I ask that you and my other distinguished colleagues join me in thanking Regina Mainor for her work and congratulating her on the occasion of her retirement.

CONGRATULATING HERMAN AND MARJORIE WILLIAMS ON 60TH ANNIVERSARY

HON. BARBARA LEE
OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Ms. LEE of California. Madam Speaker, I rise today along with my esteemed colleague from Maryland, ELIJAH CUMMINGS, in order to congratulate Herman and Marjorie Williams of Baltimore, Maryland, as they celebrate sixty years of marriage. Since they exchanged their vows on November 24, 1949, these high school sweethearts have been extraordinary parents, friends, and members of their community.

Over the decades of their marriage, they contended against racism and segregation as they pursued their careers. Herman as one of the first black firefighters in Baltimore and Marjorie at Westinghouse. Their commitment to hard work and to their family never wavered.

Herman eventually became the nation’s first African-American major-city fire chief and Marjorie retired after a long and exemplary career. Even after her retirement, Marjorie has volunteered her time with many charitable organizations, dedicating herself to helping the less fortunate. Always an adventurous spirit, she has also continued to pursue her love of travel.

The two of them together raised four wonderful and successful children: Marjorie, Ciolita, Montel, and Herman. Marjorie and Herman have a fierce dedication to their family, and the values they instilled led their children to prominent careers in the arts, education, civil service, and broadcast media.

The Williams have been an inspiration to their friends, their family, to their community, and to everyone determined to triumph in the face of adversity.

On November 28, 2009, they celebrated their anniversary along with family and friends. Please join us in wishing them the best of luck as they continue to spend their lives loving and supporting each other and bringing joy and happiness to their family and friends.

IN MEMORY OF MRS. SARA BISSELL

HON. SUE WILKINS MYRICK
OF NORTH CAROLINA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mrs. MYRICK. Madam Speaker, I rise today in memory of one of my constituents, Mrs. Sara Bissell, of Charlotte, North Carolina. Mrs. Bissell passed away after a brave 11-year battle with cancer on November 8, 2009 at the age of 71. Born in Charlotte and the granddaughter of former North Carolina Governor Cameron Morrison, Mrs. Bissell attended Charlotte Country Day School and graduated from Bennett Junior College in New York.

Mrs. Bissell took over her mother’s fine furnishing store in 1964 and ran it until recently. Her interior design influence can be seen throughout Charlotte’s buildings and landmarks. Sara’s contributions to her community were many and varied. She worked tirelessly, both out front and behind the scenes, to make Charlotte a better place. She served on the board of directors for Charlotte Country Day School, University of North Carolina—Charlotte, YMCA of Greater Charlotte, and Queens University. The Chancellor’s residence at UNCC is named in her honor.

Sara married H.C. “Smoky” Bissell, a successful developer, in 1960. Together they had four children and nine grandchildren whom they loved and cherished. She was also the sister of Charlene Bissell Cannon and Cameron Harris. Mrs. Bissell will be greatly missed by her family, friends, and the Charlotte community.

OUR UNCONSCIONABLE NATIONAL DEBT

HON. MIKE COFFMAN
OF COLORADO
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. COFFMAN of Colorado. Madam Speaker, this morning our national debt was $12,089,226,465,642.57. On January 6th, 2009, the start of the 111th Congress, the national debt was $10,538,425,742,830. This means the national debt has increased by $1,450,791,318,772 so far this year. According to the non-partisan Congressional Budget Office, the forecast deficit for this year is $1.6 trillion. That means that so far this year, we borrowed and spent an average of $4.4 billion a day more than we have collected, passing that debt and its interest payments to our children and all future Americans.

HON. ILEANA ROS-LEHTINEN
OF FLORIDA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Ms. ROS-LEHTINEN. Madam Speaker, I would like to recognize several outstanding individuals from my South Florida community who have been named to serve on the National Museum of the American Latino Commission. These individuals are not only dedicated to the mission of making a National Museum of the American Latino a reality, but they are also representative of the great diversity of the Hispanic community that the museum will showcase.

The story and history of Hispanic-Americans is part of the rich tapestry of this nation’s history. Hispanics have enriched our great nation in a myriad of ways. Hispanics have served proudly in America’s defense from the American Revolution to our current engagement in Iraq and Afghanistan. The number of Hispanic-owned businesses approached 3 million in 2008 and they contribute approximately $320 billion dollars annually to the U.S. economy.

The Hispanic-American experience is part and parcel of the American story. I will be honored to join these talented men and women tomorrow with the rest of the members of the Commission. Through their efforts, Americans from all walks of life will one day be able to see and appreciate the contributions of Hispanic-Americans to our great nation.
LEGISLATION TO EXPAND THE ARMY CORPS OF ENGINEERS’ ROLE IN CHESAPEAKE BAY RESTORATION

HON. JOHN P. SARABANES
OF MARYLAND
IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. SARABANES. Madam Speaker, I rise today to re-introduce legislation that would strengthen and expand the Army Corps of Engineers’ role in Chesapeake Bay restoration—a mission they first began in 1996. This legislation would provide the Corps with continuing authority to engage in this work; expand the Corps’ work to all six States in the Bay watershed and the District of Columbia; and provide flexibility for the Corps to work with other Federal agencies, State and local governments, and not-for-profit groups engaged in Bay cleanup.

As the Congress begins to consider the reauthorization of the Water Resources Development Act, we must take this opportunity to strengthen the role that the Army Corps of Engineers plays in Chesapeake Bay cleanup. We must turn the tide in the Bay cleanup effort so future generations can continue to enjoy the cultural, historic, and recreational benefits of the Bay and so it can continue to be an economic driver for the Mid-Atlantic region. The Corps can play an important role in that effort.

The Chesapeake Bay Environmental Restoration and Protection Program, which was established in section 510 of WRDA 1996, authorizes the Army Corps of Engineers to provide design and construction assistance to State and local authorities in the environmental restoration of the Chesapeake Bay. These projects range from shoreline buffers to oyster reef construction. As it is currently structured however, the program has been limited in its scope for several reasons. First, the Corps’ restoration efforts have been limited to Maryland, Virginia, and Pennsylvania, which has precluded a comprehensive, watershed-wide plan that adequately prioritizes projects. Second, unlike all other major Federal agencies engaged in Bay restoration, the Corps has no small watershed grants program that engages State and local governments or non-profits in small scale restoration projects. This limitation is compounded by the Corps’ intricate procurement processes. Finally, the matching fund requirements of the section 510 program do not allow for the use of in-kind services or contributions, which limits collaboration.

The Chesapeake Bay Commission, a multi-State legislative assembly dedicated to the restoration of the Bay, has previously identified these deficiencies and has recommended the several improvements to the program that are the basis for this legislation. For these reasons, I believe the bill would strengthen the section 510 program so that the Army Corps of Engineers can continue to be a strong partner in Chesapeake Bay cleanup.

I hope my colleagues will continue to support this legislation through the upcoming WRDA process.

EXPRESSING SUPPORT FOR GREATER AWARENESS OF OVARIAN CANCER

SPEECH OF
HON. MICHAEL M. HONDA
OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES

Tuesday, December 1, 2009

Mr. HONDA. Mr. Speaker, I rise today to express my strong support for H. Res. 727, emphasizing the need for greater awareness about ovarian cancer and adopting the goals and ideals established by National Ovarian Cancer Awareness Month. Having lost my wife of 36 years, Jeanne, to ovarian cancer in 2004, I am acutely sensitive to the need for reliable early detection programs and effective treatments for late stage ovarian cancer. I am not alone in having lost a loved one to this disease—ovarian cancer is the deadliest of all gynecologic cancers, affecting over 20,000 women a year. Ovarian cancer is the fifth leading cause of cancer death in women, killing nearly 55 percent of those diagnosed within the first 3 years. Despite this tragically high toll, we still remain woefully ignorant of proper prevention strategies for ovarian cancer, and have yet to develop a reliable early detection program.

While over 90 percent of ovarian cancer cases can be prevented with early screening and treatment, many women remain unaware of their risk factors and the early symptoms of ovarian cancer are particularly difficult to accurately diagnose. Because of this, 75 percent of ovarian cancer cases are diagnosed in the advanced stages where it is often too late to prevent the cancer’s spread. Awareness and early recognition are the best way to save women’s lives.

Congress is making some effort to address the inadequacies in our current system. For example, in November 2005, the House passed the Gynecological Resolution for the Advancement of Ovarian Cancer Education in a bipartisan effort to increase the public’s understanding of this deadly disease. The President and nonprofit advocacy groups are also engaged in educating the public. President Obama proclaimed September National Ovarian Cancer Awareness Month and throughout September, the Ovarian Cancer National Alliance held hundreds of events across the country to inform women about the importance of gynecologic exams, and to teach them about the warning signs of ovarian cancer.

Better education, more funding for research, and increased awareness efforts are critical to ensuring that we reduce infection and mortality rates for ovarian cancer in women. I urge my colleagues to continue our efforts to increase research funding to cure ovarian cancer and support public outreach programs on the prevention and treatment of gynecological cancers.

RECOGNIZING NOVEMBER AS NATIONAL DIABETES MONTH

SPEECH OF
HON. DIANA DeGETTE
OF COLORADO
IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Ms. DeGETTE. Madam Speaker, this week the co-chairs of the Congressional Diabetes Caucus joined with 129 original cosponsors to introduce H. Res. 914, a resolution supporting the observance of National Diabetes Month.

The resolution encourages people in the United States to fight diabetes through raising public awareness about stopping diabetes and increasing education about the disease. It also recognizes the importance of early detection, awareness of the symptoms of diabetes, and the risk factors for type 2 diabetes. Finally, it supports decreasing the prevalence of diabetes, developing better treatments and working toward an eventual cure for type 1 and type 2 diabetes.

Since diabetes afflicts nearly 24 million Americans and is the seventh leading cause of death, we must increase awareness and encourage the research to find cures. National Diabetes Month is observed every November and is an excellent way to build awareness about both type 1 and type 2 diabetes. Too many people are not familiar with the differences between type 1 and type 2 diabetes and how they are treated, what the risk factors are, and what sort of research is needed to make progress in the fight against this disease.

That is why the mission of the Congressional Diabetes Caucus is to educate Members of Congress and their staff about diabetes. It is also our mission to support legislation and other efforts to improve diabetes research, education, and treatment.

The legislative priorities of the Congressional Diabetes Caucus support the goals and ideals of National Diabetes Month. For example, H.R. 1995, The Eliminating Disparities in Diabetes Prevention, Access and Care Act, is designed to promote research, treatment, and education regarding diabetes in minority populations. This specific focus will help us address the unique challenges faced by minority populations and provide more effective treatment and education.

HINI VACCINE FOR PRISONERS

SPEECH OF
HON. TED POE
OF TEXAS
IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 2, 2009

Mr. POE of Texas. Madam Speaker, as we all know there is limited supply of the H1N1 vaccines all over our country. In Texas, there was news that prisoners could receive the swine flu vaccine before children and pregnant women. There are over 45,000 inmates who are evidently in the “high-risk” group in Texas. The correctional institutions believe that the convicts deserve to be vaccinated. Due to the limited number of vaccines available for Texas, the inmates may not receive them as soon as they wish.

By what logic do you justify having inmates receive vaccinations as a higher priority than pregnant women and children? These individuals are the most vulnerable among us and should be of great concern; not to mention senior adults, caregivers, and many others that should be high on the list. When these vaccines are provided to the states it should go to our taxpayers before our “high risk” convicts. The government needs to step up to the plate and provide the available vaccines to the people who need them the most—the children.
H.R. 1625, the Equity and Access for Podiatric Physicians Under Medicaid Act, would classify podiatrists as physicians for purposes of direct reimbursement through the Medicaid program. Podiatry is critical to the treatment and understanding of diabetes.

The Medicare Diabetes Self-Management Training Act, H.R. 2425, would make a technical clarification to recognize certified diabetes educators (CDE) as providers for Medicare diabetes outpatient self-management training services (DSMT). CDEs are the only health professionals who are specially trained and uniquely qualified to teach patients with diabetes how to improve their health and avoid serious diabetes-related complications. The 1997 authorizing DSMT statute did not include CDEs as Medicare providers. This exclusion has made it increasingly difficult to ensure that DSMT is available to patients who need these services, particularly those with unique cultural needs or who reside in rural areas.

Another bill that is a priority of the caucus is the Preventing Diabetes in Medicare Act, H.R. 2590. This bill would extend Medicare coverage for medical nutrition therapy (MNT) services for people with pre-diabetes and other risk factors for developing type 2 diabetes. Under current law, Medicare pays for MNT provided by a Registered Dietitian for beneficiaries with diabetes and renal diseases. Unfortunately, Medicare does not cover MNT for beneficiaries diagnosed with pre-diabetes. Nutrition therapy services have proven very effective in preventing diabetes by providing access to the best possible nutritional advice about how to handle their condition. By helping people with pre-diabetes manage their condition, Medicare will avoid having to pay for the much more expensive treatment of diabetes.

In addition, we are working hard to pass, H.R. 3686, and reauthorize the Special Diabetes Programs for Type I Diabetes and Indians. This program provides federal funding for the Special Statutory Funding Program for Type 1 Diabetes Research at the National Institutes of Health and the Special Diabetes Program for Indians at the Indian Heath Service. H.R. 3686 would extend these critical programs through 2016 and increase funding for both programs to $200 million a year.

I want to thank my colleague, Congressman Mike Castle, for his many years of leadership working together with me as Co Chair of the Diabetes Caucus. I also want to thank the many Members who are supporting this effort and both sides of the House leadership for their bipartisan support of diabetes issues. I look forward to working with the Congressional Diabetes Caucus to pass the important legislation we are promoting and continuing to further the goals of National Diabetes Month.

RECOGNITION OF THE PILOT CLUB OF COLUMBUS ON ITS 70TH YEAR OF SERVICE

HON. MARY JO KIRBY
OF OHIO
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Ms. KIRBY. Madam Speaker, I rise today to honor the Pilot Club of Columbus for seventy years of service to the Columbus community. The Pilot Club is a volunteer service organization that focuses on helping those with brain-related disorders, such as Alzheimer’s disease, autism, chemical dependency, traumatic brain injuries, and other disabilities.

Pilot International was founded in Macon, Georgia in October 1921 to provide volunteer services and to raise funds for those with brain-related disorders. In 1939, Pilot International chartered the Pilot Club of Columbus. Over the last seven decades, this organization has promoted awareness and prevention of brain-related disorders in Central Ohio and has provided assistance to individuals and families who are living with developmental, emotional, and mental disabilities.

The Pilot Club of Columbus creates a valuable network of service-minded individuals who have contributed to our community in numerous ways. In recent years, Columbus Pilot Clubs have provided furniture for a new senior citizen center and organized celebrations for patients at the former Ohio Psychiatric Hospital who have suffered from brain-related disorders such as Alzheimer and autism. The Pilot Club has also, and to a greater degree, helped individuals with autism and other neurological disorders and supports the BrainMinders project, which spreads information about preventing traumatic brain injury.

The Pilot Club has spent seven decades serving those who are struggling with the painful and complicated challenges associated with brain-related disorders. The Columbus Pilot Clubs have demonstrated their generosity, compassion, and commitment to making a difference in the city of Columbus. I am proud to recognize and honor the Pilot Club of Columbus and all of its dedicated volunteers for 70 years of valuable service.

EXPRESSING SUPPORT FOR GREATER AWARENESS OF OVARIAN CANCER

SPREE CH OF
HON. SHEILA JACKSON-LEE
OF TEXAS
IN THE HOUSE OF REPRESENTATIVES
Tuesday, December 1, 2009

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise before you today in support of H. Res. 727, “supporting the goals and ideals of National Ovarian Cancer Awareness Month.” I would like to thank my colleague Congresswoman STEVE ISRAEL for his leadership on this very important issue, as ovarian cancer is the 5th leading cause of cancer deaths among women in the United States.

Ovarian cancer is the deadliest of all gynecological cancers. All women are at risk for ovarian cancer, but older women are more likely to get the disease than younger women. About 90 percent of women who get ovarian cancer are older than 40 years of age, with the greatest number being aged 55 years or older. Additionally, 90 percent of women diagnosed with ovarian cancer do not have a family history that puts them at higher risk. Early detection is vital, only 20 percent of ovarian cancers are found before tumor growth has spread beyond the ovaries. The chance of surviving ovarian cancer is better if the cancer is found early. Unfortunately, there is currently no reliable early detection test for ovarian cancer.

Among women in the United States, ovarian cancer is the eighth most common cancer and the fifth leading cause of cancer death, after lung and bronchus, breast, colorectal, and pancreatic cancers. Ovarian cancer causes more deaths than any other cancer of the female reproductive system. In 2005, 19,842 women in the U.S. learned they had ovarian cancer, and 14,787 women died from the disease.

Ovarian cancer is known as a “silent killer” because it usually isn’t found until it has spread to other areas of the body. Unfortunately, there is no simple and reliable way to test for ovarian cancer in women and the Pap test does not check for ovarian cancer. However, new evidence shows that most women may have symptoms even in the early stages, such as: bloating, pelvic or abdominal pain, difficulty eating or feeling full quickly, and urinary symptoms, among several other symptoms that are easily confused with other diseases. This new evidence has led to the first national consensus statement on ovarian cancer symptoms to provide consistency in describing symptoms to make it easier for women to learn and remember them. Awareness of symptoms may hopefully lead to earlier detection.

The mortality rate for ovarian cancer has not significantly decreased in the almost 40 years since the ‘War on Cancer’ was declared. If ovarian cancer is diagnosed and treated at an early stage before the cancer spreads outside of the ovary, the survival rate is as high as 90 percent. However, due to the lack of a reliable screening test, 75 percent of ovarian cancer cases are diagnosed in an advanced stage when the five-year survival rate is below 45 percent.

I urge my colleagues to support the goals and ideals of National Ovarian Cancer Awareness Month. Education and awareness of ovarian cancer will save the lives of countless women.

HONORING EARRL HALL
OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. RADANOVICH. Madam Speaker, I rise today to commend and congratulate Earl Hall upon being awarded with the “Community Health Champions Award” at the 2009 West Fresno Health Care Coalition’s 5th annual “This is Your Life of Service” lunch and awards ceremony. This year the ceremony will be held at the Radisson Hotel Conference Center in Fresno, California on Tuesday, November 3rd.

Mr. Earl Hall was born in Oklahoma. When he was just six months old, the 1940’s “Dust Bowl” hit his family’s farm and they were forced to leave the area. Upon migrating to California, his family settled in Wasco, California. Mr. Hall’s father was finally able to find employment as a farm manager for a family farm. Mr. Hall graduated from Wasco High School then attended Bakersfield Junior College and Fresno City College, where he earned his Associates degree. He transferred to California State University, Fresno and graduated with a Bachelor’s degree in Agricultural Business in 1964.

Mr. Hall has dedicated his career to establishing and developing his business, Hall Ag
Enterprises. For the past forty-four years he has provided labor services with a safe and secure environment for his employees. During periods of water shortages, he has searched for other opportunities to place his workers to ensure that they are able to work and are able to provide for their families. Mr. Hall holds licenses that allow him to provide farm labor in twenty-nine countries. His business provides services to more than three hundred thousand acres and employs nearly thirty thousand people through out the state of California.

Beyond his generosity to his employees, Mr. Hall is dedicated to his community as well. He has provided financial assistance to various causes including health care, charitable organizations and child services. Mr. Hall is part of the Farm Labor Contractors Alliance, the California Association of Agricultural Labor and an active member of Ag SAFE. He is currently serving as the Chairman for the Fresno County Farm Bureau Labor Committee and the Rural Health and Safety Committee. In 2003, Mr. Hall was awarded the “Central California Excellence in Business Award” by The Fresno Bee.

As a young man, Mr. Hall was turned pro in the rodeo circuit; he is a lifetime member of the Professional Rodeo Cowboy’s Association and is a “gold card” holder which allows him to compete in the over-fifty age group. He is involved in rodeo events by assisting and providing advice and mentorship to youth preparing for rodeo events.

Madam Speaker, I rise today to commend and congratulate Earl Hall upon being awarded with the “Community Health Champions Award.” I invite my colleagues to join me in wishing Mr. Hall many years of continued success.

IN RECOGNITION OF STRAFFORD HIGH SCHOOL FLAMING ARROW INDIAN PRIDE MARCHING BAND

HON. ROY BLUNT
OF MISSOURI
IN THE HOUSE OF REPRESENTATIVES
Wednesday, December 2, 2009

Mr. BLUNT. Madam Speaker, I rise today with pleasure and pride to pay tribute to the achievements of the Music Department at Strafford High School in Strafford, Missouri. The Strafford High Flaming Arrow Indian Pride Marching Band and choir will participate in the events surrounding the December 31, 2009, Chick-fil-A Bowl in Atlanta, Georgia. A long-standing event at the bowl game is the National Chick-fil-A Bowl Parade in downtown Atlanta on New Year’s Eve. Game day, the Strafford band will participate in a pre-game and halftime massed band “extravaganza” of 2,000 members performing in the Georgia Dome Olympic Stadium.

Strafford, Missouri, is my hometown. Today, Strafford has a population of 1,845 citizens, and the school has approximately 400 students. The band and choir are made up of 55 motivated, hardworking teens in concert and marching band, 20 students in jazz band and 36 students in choir. The music department is under the direction of Shane Harmon. The Strafford High Flaming Arrow Indian Pride Marching Band consistently ranks among the best bands in Missouri, earning first place at six judged events this year. At the 2007 Outdoor Odyssey, Florida, the Strafford concert band, jazz band and marching band each earned a 1st place Silver rating, and the concert choir earned a 1st place Gold rating. These achievements led to the invitation to participate at the band festival at the Chick-fil-A Bowl. This recognition is the result of years of practice, and dedication to excellence by Strafford students, faculty and their families.

SENATE COMMITTEE MEETINGS

Title IV of Senate Resolution 4, agreed to by the Senate on February 4, 1977, calls for establishment of a system for a computerized schedule of all meetings and hearings of Senate committees, subcommittees, joint committees, and committees of conference. This title requires all such committees to notify the Office of the Senate Daily Digest—designated by the Rules Committee—of the time, place, and purpose of the meetings, when scheduled, and any cancellations or changes in the meetings as they occur.

As an additional procedure along with the computerization of this information, the Office of the Senate Daily Digest will prepare this information for printing in the Extensions of Remarks section of the CONGRESSIONAL RECORD on Monday and Wednesday of each week.

Meetings scheduled for Thursday, December 3, 2009 may be found in the Daily Digest of today’s RECORD.

MEETINGS SCHEDULED

DECEMBER 4

9:30 a.m.

Joint Economic Committee

To hold hearings to examine the employment situation for November 2009.

SH–216

DECEMBER 8

10 a.m.

Environment and Public Works

To hold an oversight hearing to examine Federal drinking water programs.

SD–406

1:30 p.m.

Armed Services

To hold hearings to examine Afghanistan.

SH–216

2:15 p.m.

Foreign Relations

Business meeting to consider S. 1559, to consolidate democracy and security in the Western Balkans by supporting the Governments and people of Bosnia and Herzegovina and Montenegro in reaching their goal of eventual NATO membership, and to welcome further NATO partnership with the Republic of Serbia and Slovenia, and the nominations of Jaziv J. Shah, of Washington, to be Ambassador of the United States Agency for International Development, and Mary Burke Warlick, of Virginia, to be Ambassador to the Republic of Serbia, James B. Warlick, Jr., of Virginia, to be Ambassador to the Republic of Bulgaria, Eleni Tsakopoulos Kounalakis, of California, to be Ambassador to the Republic of Hungary, Leslie V. Rowe, of Washington, to be Ambassador to the Republic of Mozambique, Alberto M. Fernandez, of Virginia, to be Ambassador to the Republic of Equatorial Guinea, Mary Jo Wills, of the District of Columbia, to be Ambassador to the Republic of Mauritius, and to serve concurrently and without additional compensation as Ambassador to the Republic of Seychelles, Jide J. Zeitlin, of New York, to be Alternate Representative of the United States of America to the America to the Session of the General Assembly of the United Nations during his tenure of service as Representative of the United States of America to the United Nations for U.N. Management and Reform, with the rank of Ambassador, and Bill Lachen- setts, Elaine Schuster, of Florida, and Christopher H. Smith, of New Jersey, all to be a Representative, and Laura Geer Ross, of New York, to be Ambas- sador to the Republic of Georgia, and Wel- lington E. Webb, of Colorado, both to be an Alternate Representative, all of the United States of America to the Sixty-fourth Session of the General Assem- bly of the United Nations, all of the Department of State.

S–116, Capitol

2:30 p.m.

Energy and Natural Resources

Energy Subcommittee

To hold hearings to examine H.R. 957, to authorize higher education curriculum development and demonstration training in advanced energy and green building technologies, H.R. 2729, to authorize the designation of National Environmental Research Parks by the Secretary of Energy, H.R. 3165, to provide for a program of wind energy research, development, and demonstration, H.R. 3269, to provide for intermittent renewable energy research, demonstration, and commercial application in vehicle technologies at the Department of Energy, H.R. 3353, to authorize the Secretary of Energy to include a financial award for separation of carbon dioxide from dilute sources, and S. 2773, to require the Secretary of Energy to improve energy efficiency and produce clean energy technology, S. 737, to amend the Energy Independence and Security Act of 2007 to authorize the Secretary of Energy to conduct research, development, and demonstration to make biofuels more compatible with small nonroad engines, S. 1617, to require the Secretary of Commerce to establish a program for the award of grants to States to establish revolving loan funds for small and medium-size manufacturers to improve energy efficiency and produce clean energy technology, S. 2744, to amend the Energy Policy Act of 2005 to expand the authority for awarding technology prizes by the Secre- tary of Energy to include a financial award for separation of carbon dioxide from dilute sources, and S. 2737, to re- quire the Secretary of Energy to carry out a program to support the research, demonstration, and development of commercial applications for offshore wind energy.

SD–366

Intelligence

To hold closed hearings to consider certain intelligence matters.

S–407, Capitol
9:30 a.m.
Indian Affairs
Business meeting to consider pending calendar business; to be immediately followed by a hearing to examine S. 1690, to amend the Act of March 1, 1933, to transfer certain authority and resources to the Utah Dineh Corporation; to be immediately followed by an oversight hearing to examine Department of the Interior backlogs.
SD–628

10 a.m.
Health, Education, Labor, and Pensions
Business meeting to consider the nominations of Jacqueline A. Berrien, of New York, Victoria A. Lipnic, of Virginia, Chai R. Feldblum, of Maryland, all to be a Member of the Equal Employment Opportunity Commission, P. David Lopez, of Arizona, to be General Counsel of the Equal Employment Opportunity Commission, Patrick Alfred Corvinton, of Maryland, to be Chief Executive Officer of the Corporation for National and Community Service, Adele Logan Alexander, of the District of Columbia, to be a Member of the National Council on the Humanities, and Lynnae M. Rutledge, of Washington, to be Commissioner of the Rehabilitation Services Administration, Department of Education.
SD–430

10 a.m.
Homeland Security and Governmental Affairs
To hold hearings to examine the nominations of Robert A. Petzel, of Minnesota, to be Under Secretary for Health, and Raul Perea-Henze, of New York, to be Assistant Secretary for Policy and Planning, both of the Department of Veterans Affairs.
SR–418

2:30 p.m.
Commerce, Science, and Transportation
To hold hearings to examine research parks and job creation, focusing on innovation through cooperation.
SR–253

Finance
International Trade, Customs, and Global Competitiveness Subcommittee
To hold hearings to examine exports’ place on the path of economic recovery.
SD–215

Homeland Security and Governmental Affairs
Oversight of Government Management, the Federal Workforce, and the District of Columbia Subcommittee
To hold hearings to examine the diplomat’s shield, focusing on diplomatic security today.
SD–342

2:30 p.m.
Commerce, Science, and Transportation
To hold hearings to examine certain intelligence matters.
S–407, Capitol

10 a.m.
Energy and Natural Resources
To hold hearings to examine S. 2052, to amend the Energy Policy Act of 2005 to carry out a research and development and demonstration program to reduce manufacturing and construction costs relating to nuclear reactors, and S. 2812, to amend the Energy Policy Act of 2005 to require the Secretary of Energy to carry out programs to develop and demonstrate small modular nuclear reactor designs.
SD–366

10 a.m.
Foreign Relations
SD–419

10 a.m.
Foreign Relations
To hold hearings to examine the nominations of Grayling Grant Williams, of Maryland, to be Director of the Office of Counternarcotics Enforcement, and Elizabeth M. Harman, of Maryland, to be an Assistant Administrator of the Federal Emergency Management Agency, both of the Department of Homeland Security.
SD–342

2:30 p.m.
Commerce, Science, and Transportation
Business meeting to consider pending calendar business.
SR–253

2:30 p.m.
Energy and Natural Resources
Public Lands and Forests Subcommittee
To hold hearings to examine S. 1470, to sustain the economic development and recreational use of National Forest System land and other public land in the State of Montana, to add certain land to the National Wilderness Preservation System, to release certain wilderness study areas, to designate new areas for recreation, S. 1719, to provide for the conveyance of certain parcels of land to the town of Alta, Utah, S. 1787, to reauthorize the Federal Land Transaction Facilitation Act, H.R. 762, to validate final patent number 27–2005–0081, and H.R. 934, to convey certain submerged lands to the Commonwealth of the Northern Mariana Islands in order to give that territory the same benefits in its submerged lands as Guam, the Virgin Islands, and American Samoa have in their submerged lands.
SD–366
Chamber Action

Routine Proceedings, pages S12093–S12260

Measures Introduced: Two bills and one resolution were introduced, as follows: S. 2823–2824, and S. Res. 366.

Measures Passed:

Extending Condolences to the Families of Fallen Lakewood Police Department Officers: Senate agreed to S. Res. 366, extending condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards.

Measures Considered:

Service Members Home Ownership Tax Act—Agreement: Senate continued consideration of H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, taking action on the following amendments proposed thereto:

Adopted:

Vitter Amendment No. 2808 (to Amendment No. 2791), to prevent the United States Preventive Service Task Force recommendations from restricting mammograms for women.

Pages S12094–S12106, S12106–52

Pending:

Reid Amendment No. 2786, in the nature of a substitute.

Mikulski Amendment No. 2791 (to Amendment No. 2786), to clarify provisions relating to first dollar coverage for preventive services for women.

Pages S12094, S12113–52

McCain motion to commit the bill to the Committee on Finance, with instructions.

Pages S12094

A unanimous-consent-time agreement was reached providing for further consideration of the bill after any Leader time on Thursday, December 3, 2009, and that it be in order for any of the Majority or Republican bill managers to be recognized for a total period of time not to exceed 10 minutes, equally divided and controlled; that the time until 11:45 a.m. be equally divided and controlled between Senator Mikulski and the Republican Leader, or their designees; that the time until 11:45 a.m., be for debate with respect to Mikulski Amendment No. 2791 (to Amendment No. 2786) (listed above), as amended, and McCain motion to commit the bill to the Committee on Finance, with instructions (listed above); and during this time, it be in order for Senator Murkowski to call up her amendment with respect to mammography, a copy of which is at the desk; and that it also be in order for Senator Bennett to call up Amendment No. 2826, a side-by-side amendment with respect to the McCain motion to commit (listed above); that no other amendments or motions to commit be in order during the pendency of these amendments and motion; that at 11:45 a.m., Senate vote on or in relation to Mikulski Amendment No. 2791 (to Amendment No. 2786) (listed above), as amended; that upon disposition of the Mikulski Amendment; Senate then vote on or in relation to Murkowski amendment; that upon disposition of these two amendments, Senate continue to debate until 2:45 p.m., Bennet Amendment No. 2826, and McCain motion to commit (listed above); with the time equally divided and controlled between Senators Baucus and McCain, or their designees; that at 2:45 p.m., Senate vote on or in relation to Bennet Amendment No. 2826, that upon disposition of that amendment, Senate vote on or in relation to McCain motion to commit (listed above); that prior to the second vote in each sequence, there be two minutes of debate, equally divided and controlled in the usual form; that each of the above referenced amendments or motion be subject to an affirmative 60 vote threshold, and that if the amendments or motion do not achieve that threshold, then they be withdrawn; provided further, that if any of the above listed achieve the 60 vote threshold, then the amendment or motion be agreed to; provided further, that it be in order if there is a request for the yeas and nays to be ordered with respect to that amendment or motion, regardless of achieving the 60 vote threshold; that if the yeas and nays requested are requested, the vote would occur immediately with no further debate in order with respect to this particular consent.

Pages S12150–52, S12259
Nominations Received: Senate received the following nominations:

David W. Mills, of Virginia, to be an Assistant Secretary of Commerce.

Douglas A. Rediker, of Massachusetts, to be United States Alternate Executive Director of the International Monetary Fund for a term of two years.

Michael A. Khouri, of Kentucky, to be a Federal Maritime Commissioner for a term expiring June 30, 2011.

6 Coast Guard nominations in the rank of admiral.

Routine lists in the Air Force and Navy.

Messages from the House: Pages S12156–57
Measures Referred: Page S12157
Enrolled Bills Presented: Page S12157
Executive Communications: Pages S12157–59
Executive Reports of Committees: Pages S12159–60
Additional Cosponsors: Pages S12160–62
Statements on Introduced Bills/Resolutions: Page S12162

Additional Statements: Pages S12155–56
Amendments Submitted: Pages S12162–S12258
Notices of Hearings/Meetings: Pages S12258–59
Authorities for Committees to Meet: Page S12259

Adjournment: Senate convened at 9:30 a.m. and adjourned at 8:31 p.m., until 9:30 a.m. on Thursday, December 3, 2009. (For Senate’s program, see the remarks of the Acting Majority Leader in today’s Record on page S12260.)

Committee Meetings
(Committees not listed did not meet)

DERIVATIVES REFORM AND SYSTEMIC RISK

Committee on Agriculture, Nutrition, and Forestry: Committee concluded a hearing to examine over-the-counter derivatives reform and addressing systemic risk, after receiving testimony from Timothy F. Geithner, Secretary of the Treasury; Terrence A. Duffy, CME Group, Inc., Chicago, Illinois; Johnathan Short, IntercontinentalExchange, Inc., Atlanta, Georgia; and Peter Axilrod, Depository Trust and Clearing Corporation, Blythe Masters, JPMorgan Chase and Co., and Jiro Okochi, Reval.com, Inc., all of New York, New York.

AFGHANISTAN

Committee on Armed Services: Committee concluded a hearing to examine Afghanistan, after receiving testimony from Hillary Rodham Clinton, Secretary of State; and Robert M. Gates, Secretary, and Admiral Michael G. Mullen, USN, Chairman of the Joint Chiefs of Staff, both of the Department of Defense.

NOMINATIONS

Committee on Armed Services: Committee ordered favorably reported the nominations of Clifford L. Stanley, of Pennsylvania, to be Under Secretary for Personnel and Readiness, Frank Kendall III, of Virginia, to be Principal Deputy Under Secretary for Acquisition, Technology, and Logistics, Erin C. Conaton, of the District of Columbia, to be Under Secretary of the Air Force, Terry A. Yonkers, of Maryland, to be Assistant Secretary of the Air Force, and Lawrence G. Romo, of Texas, to be Director of the Selective Service, all of the Department of Defense.

Also, Committee ordered favorably reported 1,938 nominations in the Army, Navy, and Air Force.

TRANSPORTATION SECURITY CHALLENGES

Committee on Commerce, Science, and Transportation: Committee concluded a hearing to examine transportation security challenges post-September 11, 2001 terrorist attacks, after receiving testimony from Janet Napolitano, Secretary of Homeland Security.

REDUCING GREENHOUSE GAS EMISSIONS


TOXIC SUBSTANCES CONTROL ACT

Committee on Environment and Public Works: Committee concluded an oversight hearing with the Subcommittee on Superfund, Toxics and Environmental Health to examine the Federal Toxic Substances Control Act, focusing on obtaining more information on chemical risks, controlling these risks, and sharing information collected, after receiving testimony from Lisa P. Jackson, Administrator, Environmental Protection Agency; John Stephenson, Director, Natural Resources and Environment, Government Accountability Office; and Linda S. Birnbaum, Director, National Institute of Environmental Health Sciences, National Institutes of Health, and National...
Toxicology Program, Department of Health and Human Services.

**DISASTER CASE MANAGEMENT**

Committee on Homeland Security and Governmental Affairs: Ad Hoc Subcommittee on Disaster Recovery concluded a hearing to examine disaster case management, focusing on developing a comprehensive national program focused on outcomes, how did the federal government support disaster case management programs after Hurricanes Katrina and Rita, and how federal agencies coordinate their efforts, what challenges did disaster case management agencies experience in delivering services under federally funded programs, and how will previous or existing federally funded programs be used to inform the development of a federal case management program for future disasters, after receiving testimony from Elizabeth A. Zimmerman, Assistant Administrator, Disaster Assistance, Federal Emergency Management Agency, Department of Homeland Security; David Hansell, Principal Deputy Assistant Secretary of Health and Human Services for Administration for Children and Families; Frederick Tombar, Senior Advisor, Office of the Secretary, Department of Housing and Urban Development; Kay E. Brown, Director, Education, Work, and Income Security, Government Accountability Office; Stephen Carr, Mississippi Case Management Consortium, Mobile, Alabama; Amanda Guma, Human Services Policy Director, Louisiana Recovery Authority, and Monteic A. Sizer, Louisiana Family Recovery Corps, both of Baton Rouge; Reverend Larry Snyder, Catholic Charities USA, Alexandria, Virginia; Diana Rothe-Smith, National Voluntary Organizations Active in Disaster, Arlington, Virginia; and Irwin Redlener, Columbia University Mailman School of Public Health, New York, New York.

**AMERICANS' ACCESS TO COURTS**

Committee on the Judiciary: Committee concluded a hearing to examine the Supreme Court, focusing on Americans’ access to courts, after receiving testimony from John Payton, NAACP Legal Defense and Education Fund, Inc., and Gregory G. Garre, Latham & Watkins LLP, both of Washington, D.C.; and Stephen B. Burbank, University of Pennsylvania, Philadelphia.

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**House of Representatives**

**Chamber Action**

Public Bills and Resolutions Introduced: 20 public bills, H.R. 4169–4188; and 1 resolution, H. Res. 942, were introduced. Pages H13465–66

Additional Cosponsors: Pages H13466–67

Reports Filed: Reports were filed today as follows:

- H.R. 515, to prohibit the importation of certain low-level radioactive waste into the United States, with an amendment (H. Rept. 111–348, Pt. 1);
- H.R. 2994, to reauthorize the Satellite Home Viewer Extension and Reauthorization Act of 2004, with an amendment (H. Rept. 111–349);
- H. Res. 941, providing for consideration of the bill (H.R. 4154) to amend the Internal Revenue Code of 1986 to repeal the new carryover basis rules in order to prevent tax increases and the imposition of compliance burdens on many more estates than would benefit from repeal and to retain the estate tax with a $3,500,000 exemption (H. Rept. 111–350). Pages H13427, H13465

Suspensions: The House agreed to suspend the rules and pass the following measures:

- Recognizing the exemplary service of the soldiers of the 30th Infantry Division (Old Hickory) of the United States Army during World War II: H. Res. 494, amended, to recognize the exemplary service of the soldiers of the 30th Infantry Division (Old Hickory) of the United States Army during World War II, by a 2/3 yea-and-nay vote of 415 yeas with none voting “nay”, Roll No. 914; Pages H13392–94, H13408

- Congratulating the Sailors of the United States Submarine Force upon the completion of 1,000 Ohio-class ballistic missile submarine (SSBN) deterrent patrols: H. Con. Res. 129, to congratulate the Sailors of the United States Submarine Force upon the completion of 1,000 Ohio-class ballistic missile submarine (SSBN) deterrent patrols, by a 2/3 yea-and-nay vote of 412 yeas with none voting “nay”, Roll No. 915; Pages H13394–95, H13408–09

- Supporting the goals and ideals of National Military Family Month: H. Res. 861, amended, to support the goals and ideals of National Military Family Month, by a 2/3 yea-and-nay vote of 417 yeas with none voting “nay”, Roll No. 916; Pages H13395–97, H13409–10
Agreed to amend the title so as to read: “Supporting the goals and ideals of Military Family Month.”.

Recognizing the importance of teaching elementary and secondary school students about the sacrifices that veterans have made throughout the history of the Nation; H. Res. 897, to recognize the importance of teaching elementary and secondary school students about the sacrifices that veterans have made throughout the history of the Nation, by a 2/3 yea-and-nay vote of 419 yeas with none voting “nay”, Roll No. 917;

Pages H13397–98, H13410

Airline Flight Crew Technical Corrections Act: S. 1422, to amend the Family and Medical Leave Act of 1993 to clarify the eligibility requirements with respect to airline flight crews;

Pages H13398–99

CJ’s Home Protection Act of 2009: H.R. 320, to amend the National Manufactured Housing Construction and Safety Standards Act of 1974 to require that weather radios be installed in all manufactured homes manufactured or sold in the United States;

Pages H13399–H13401

Encouraging banks and mortgage servicers to work with families affected by contaminated drywall to allow temporary forbearance without penalty on payments on their home mortgages: H. Con. Res. 197, amended, to encourage banks and mortgage servicers to work with families affected by contaminated drywall to allow temporary forbearance without penalty on payments on their home mortgages, by a 2/3 yea-and-nay vote of 419 yeas to 1 nay, Roll No. 920;

Pages H13401–04, H13425–26

Agreed to amend the title so as to read: “Encouraging banks and mortgage servicers to work with families affected by contaminated drywall and to consider adjustments to payment schedules on their home mortgages that take into account the financial burdens of responding to the presence of such drywall.”.

Page H13426

Enhanced S.E.C. Enforcement Authority Act: H.R. 2873, amended, to provide enhanced enforcement authority to the Securities and Exchange Commission;

Pages H13404–05


Pages H13405–08, H13426–27

Agreed to amend the title so as to read: “To amend the Emergency Economic Stabilization Act of 2008 to provide for additional monitoring and accountability of the Troubled Asset Relief Program.”.

Page H13427

Redundancy Elimination and Enhanced Performance for Preparedness Grants Act: H.R. 3980, amended, to provide for identifying and eliminating redundant reporting requirements and developing meaningful performance metrics for homeland security preparedness grants, by a 2/3 yea-and-nay vote of 414 yeas with none voting “nay”, Roll No. 922;

Pages H13411–13, H13427

Criminal Investigative Training Restoration Act: H.R. 3963, to provide specialized training to Federal air marshals;

Pages H13415–17

Extending condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards: H. Res. 939, to extend condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards; and

Pages H13417–19


Pages H13419–24, H13425

Moment of Silence: The House observed a moment of silence in honor of the men and women in uniform who have given their lives in the service of our nation in Iraq and Afghanistan, their families, and all who serve in the armed forces and their families.

Page H13409

Suspension—Proceedings Resumed: The House agreed to suspend the rules and pass the following measure which was debated on Tuesday, December 1st:

George Kell Post Office Designation Act: H.R. 3634, to designate the facility of the United States Postal Service located at 109 Main Street in Swifton, Arkansas, as the “George Kell Post Office”, by a 2/3 recorded vote of 415 ayes with none voting “no”, Roll No. 918.

Pages H13410–11

Suspensions—Proceedings Postponed: The House debated the following measures under suspension of the rules. Further proceedings were postponed:

Expressing the sense of the House of Representatives that the Transportation Security Administration should enhance security against terrorist attack and other security threats to our Nation’s rail and mass transit lines: H. Res. 28, amended, to express the sense of the House of Representatives that the Transportation Security Administration should,
in accordance with the congressional mandate provided for in the Implementing Recommendations of the 9/11 Commission Act of 2007, enhance security against terrorist attack and other security threats to our Nation’s rail and mass transit lines and

Satellite Home Viewer Update and Reauthorization Act of 2009: H.R. 3570, amended, to amend title 17, United States Code, to reauthorize the satellite statutory license and to conform the satellite and cable statutory licenses to all-digital transmissions.

Discharge Petition: Representative Nunes presented to the clerk a motion to discharge the Committee on Natural Resources from the consideration of H.R. 3105, to provide that operations of the Central Valley Project shall not be restricted pursuant to any biological opinion issued under the Endangered Species Act of 1973, if such restrictions would result in levels of export less than the historical maximum level of export (Discharge Petition No. 8).

Recess: The House recessed at 2:45 p.m. and reconvened at 4:15 p.m.

Quorum Calls—Votes: Eight yea-and-nay votes and one recorded vote developed during the proceedings of today and appear on pages H13408, H13408–09, H13409–10, H13410, H13411, H13425, H13425–26, H13426–27, and H13427. There were no quorum calls.

Adjournment: The House met at 10 a.m. and adjourned at 9 p.m.

Committee Meetings

CLIMATE CHANGE—FARM SECTOR ECONOMIC IMPACTS

Committee on Agriculture: Subcommittee on Conservation, Credit, Energy, and Research held a hearing to review the potential economic impacts of climate change on the farm sector. Testimony was heard from Joseph Glauber, Chief Economist, USDA; and public witnesses.

GUAM WAR CLAIMS PROCESS

Committee on Armed Services: Held a hearing on assessing the Guam war claims process. Testimony was heard from Anthony M. Babauta, Assistant Secretary, Insular Affairs, Department of the Interior; the following Senators of the Guam Legislature: Vicente Pangelinan; and Frank Blas, Jr; Mauricio Tamargo, former Chairman, Guam War Claims Review Commission; and a public witness.

WALTER REED ARMY MEDICAL CENTER

Committee on Armed Services: Subcommittee on Readiness and the Subcommittee on Military Personnel held a joint hearing on The New Walter Reed: Are We on the Right Track? Testimony was heard from the following officials of the Department of Defense: Al Middleton, Acting Principal Deputy Assistant Secretary, Health Affairs; Dorothy Robyn, Deputy Under Secretary, Installations and Environment; VADM John M. Mateczun, USN, Commander, Joint Task Force National Capital Region Medical; and Ken Kizer, Chairman, Health Board National Capital Region Base Realignment and Closure Health Systems Advisory Subcommittee.

DELPHI BANKRUPTCY—WORKERS/ RETIRES IMPACTS

Committee on Education and Labor: Subcommittee on Health, Employment, Labor and Pensions held a hearing on Examining the Delphi Bankruptcy’s Impact on Workers and Retirees. Testimony was heard from Senator Brown; Representatives Lee of New York, Ryan of Ohio and Turner; and public witnesses.

OVER-THE-COUNTER DERIVATIVES MARKETS ACT—ENERGY MARKETS

Committee on Energy and Commerce: Subcommittee on Energy and Environment held a hearing on Impacts of H.R. 3795, Over-the-Counter Derivatives Markets Act of 2009, on Energy Markets. Testimony was heard from Jon Wellinghoff, Chairman, Federal Energy Regulatory Commission, Department of Energy; Gary Gensler, Chairman CFTC; former Representative Glenn English of Oklahoma; and public witnesses.

BREAST CANCER SCREENING RECOMMENDATIONS

Committee on Energy and Commerce: Subcommittee on Health held a hearing entitled “Breast Cancer Screening Recommendations.” Testimony was heard from David Lakey, Commissioner, Department of State Health Services, State of Texas; and public witnesses.

FINANCIAL PROTECTION MEASURES


FY09 FHA ACTUARIAL REPORT

Committee on Financial Services: Held a hearing entitled “FY09 FHA Actuarial Report.” Testimony was heard from Shaun Donovan, Secretary of Housing and Urban Development; and public witnesses.
U.S. STRATEGY IN AFGHANISTAN

Committee on Foreign Affairs: Held a hearing on U.S. Strategy in Afghanistan. Testimony was heard from Hillary Rodham Clinton, Secretary of State; and the following officials of the Department of Defense: Robert M. Gates, Secretary; and ADM Michael G. Mullen, USN, Chairman, Joint Chiefs of Staff.

YOUTH PRISON REDUCTION

Committee on the Judiciary: Ordered reported, as amended, H.R. 1064, Youth Prison Reduction through Opportunities, Mentoring, Intervention, Support, and Education Act.

INDIAN ARTS AND CRAFTS AMENDMENTS ACT OF 2009

Committee on Natural Resources: Held a hearing on H.R. 725, Indian Arts and Crafts Amendments Act of 2009. Testimony was heard from Representative Pastor; Larry Parkinson, Deputy Assistant Secretary, Law Enforcement, Security and Emergency Management, Department of the Interior; and public witnesses.

MINORITY-OWNED RADIO RATINGS DECLINE

Committee on Oversight and Government Reform: Held a hearing entitled “Will Arbitron’s Personal People Meter Silence Minority Owned Radio Stations?” Testimony was heard from public witnesses.

2010 CENSUS

Committee on Oversight and Government Reform: Subcommittee on Information Policy, Census, and National Archives held a hearing entitled “The 2010 Census: How Complete Count Committees, Local Governments, Philanthropic Organizations, Not-for-Profits, and the Business Community Can Contribute to a Successful Census.” Testimony was heard from Yvette Cumberbatch, Coordinator, 2010 Census, New York City; Mercedes Lemp Jacobs, Director, Office of Latino Affairs, District of Columbia; and public witnesses.

PERMANENT ESTATE TAX RELIEF FOR FAMILIES, FARMERS, AND SMALL BUSINESSES ACT

Committee on Rules: Committee granted, by a non-record vote, a closed rule providing for consideration of H.R. 4154, the Permanent Estate Tax Relief for Families, Farmers, and Small Businesses Act of 2009. The rule provides one hour of debate equally divided and controlled by the chair and ranking majority member of the Committee on Ways and Means.

The rule waives all points of order against consideration of the bill except those arising under clause 9 or 10 of rule XXI. The rule provides that the bill shall be considered as read. The rule waives all points of order against the bill. The rule provides one motion to recommit with or without instructions.

Finally, the rule provides that in the engrossment of H.R. 4154, the Clerk shall add the text of H.R. 2920, as passed by the House, as new matter at the end of H.R. 4154. Testimony was heard from Representatives Pomroy, Berkley, Welch and Brady of Texas.

HUMAN SPACE FLIGHT SAFETY

Committee on Science and Technology: Subcommittee on Space and Aeronautics held a hearing on Ensuring the Safety of Human Space Flight. Testimony was heard from the following officials of the NASA: Jeff Hanley, Program Manager, Constellation Program, Exploration Systems Mission Directorate; John Marshall, Council Member, Aerospace Safety Advisory Panel; and Bryan O’Connor, Chief of Safety and Mission Assurance; and public witnesses.

COMMERCIAL SPACE TRANSPORTATION

Committee on Transportation and Infrastructure: Subcommittee on Aviation held a hearing on Commercial Space Transportation. Testimony was heard from George C. Nield Associate Administrator, Office of Commercial Space Transportation, FAA, Department of Transportation; Gerald Dillingham, Director, Physical Infrastructure Issues, GAO; and public witnesses.

ECONOMIC STIMULUS—GSA BORDER STATION

Committee on Transportation: Subcommittee on Economic Development, Public Buildings, and Emergency Management held a hearing on Stimulus Tracking #4: Ensuring Money Means Security when Building GSA Border Stations to Protect the U.S.A. Testimony was heard from Representatives Filner, Michaud, Ortiz, and Teague; Bill Guerin, Deputy Assistant Commissioner, Executive, Recovery Program Management Office, Public Buildings Service, GSA; Treat Frazier, Director, Land Port of Entry Modernization Program Management Office, U.S. Customs and Border Protection, Department of Homeland Security.

VA HEALTH CARE FUNDING

Committee on Veterans’ Affairs: Held a hearing on VA Health Care Funding: Appropriations to Programs. Testimony was heard from the following officials of the Department of Veterans Affairs: Rita A. Reed, Office of the Assistant Secretary, Management; and Michael S. Finegan, Director, Veterans Integrated Service Network 11; and a public witness.
STATE OF CLIMATE SCIENCE—ADMINISTRATION’S VIEW

Select Committee on Energy Independence and Global Warming: Held a hearing entitled “The Administration’s View on the State of Climate Science.” Testimony was heard from John Holdren, Director, Office of Science and Technology Policy; and Jane Lubchenco, Administrator, NOAA, Department of Commerce.

Joint Meetings

FINANCIAL REFORM

Joint Economic Committee: Committee concluded a hearing to examine unregulated markets, focusing on regulatory reform in the financial sector, after receiving testimony from Brooksley Born, former Chairperson, Commodity Futures Trading Commission; and Robert E. Litan and Robert K. Steel, both of the Pew Task Force on Financial Reform, and James H. Carr, National Community Reinvestment Coalition, all of Washington, D.C.

NEW PUBLIC LAWS

(For last listing of Public Laws, see DAILY DIGEST, p. D1329)

H.R. 955, to designate the facility of the United States Postal Service located at 10355 Northeast Valley Road in Rollingbay, Washington, as the “John ‘Bud’ Hawk Post Office”. Signed on November 30, 2009. (Public Law 111–99)

H.R. 1516, to designate the facility of the United States Postal Service located at 37926 Church Street in Dade City, Florida, as the “Sergeant Marcus Mathes Post Office”. Signed on November 30, 2009. (Public Law 111–100)

H.R. 1713, to name the South Central Agricultural Research Laboratory of the Department of Agriculture in Lane, Oklahoma, and the facility of the United States Postal Service located at 310 North Perry Street in Bennington, Oklahoma, in honor of former Congressman Wesley "Wes" Watkins. Signed on November 30, 2009. (Public Law 111–101)

H.R. 2004, to designate the facility of the United States Postal Service located at 4282 Beach Street in Akron, Michigan, as the “Akron Veterans Memorial Post Office”. Signed on November 30, 2009. (Public Law 111–102)

H.R. 2215, to designate the facility of the United States Postal Service located at 140 Merriman Road in Garden City, Michigan, as the “John J. Shivnen Post Office Building”. Signed on November 30, 2009. (Public Law 111–103)

H.R. 2760, to designate the facility of the United States Postal Service located at 1615 North Wilcox Avenue in Los Angeles, California, as the “Johnny Grant Hollywood Post Office Building”. Signed on November 30, 2009. (Public Law 111–104)

H.R. 2972, to designate the facility of the United States Postal Service located at 115 West Edward Street in Erath, Louisiana, as the “Conrad DeRouen, Jr. Post Office”. Signed on November 30, 2009. (Public Law 111–105)

H.R. 3119, to designate the facility of the United States Postal Service located at 867 Stockton Street in San Francisco, California, as the “Lim Poon Lee Post Office”. Signed on November 30, 2009. (Public Law 111–106)

H.R. 3386, to designate the facility of the United States Postal Service located at 1165 2nd Avenue in Des Moines, Iowa, as the “Iraq and Afghanistan Veterans Memorial Post Office”. Signed on November 30, 2009. (Public Law 111–107)

H.R. 3547, to designate the facility of the United States Postal Service located at 956 South 250 East in Provo, Utah, as the “Rex E. Lee Post Office Building”. Signed on November 30, 2009. (Public Law 111–108)

S. 748, to redesignate the facility of the United States Postal Service located at 2777 Logan Avenue in San Diego, California, as the “Cesar E. Chavez Post Office”. Signed on November 30, 2009. (Public Law 111–109)

S. 1211, to designate the facility of the United States Postal Service located at 60 School Street, Orchard Park, New York, as the “Jack F. Kemp Post Office Building”. Signed on November 30, 2009. (Public Law 111–110)

S. 1314, to designate the facility of the United States Postal Service located at 630 Northeast Killingsworth Avenue in Portland, Oregon, as the “Dr. Martin Luther King, Jr. Post Office”. Signed on November 30, 2009. (Public Law 111–111)

S. 1825, to extend the authority for relocation expenses test programs for Federal employees. Signed on November 30, 2009. (Public Law 111–112)

COMMITTEE MEETINGS FOR THURSDAY, DECEMBER 3, 2009

(Committee meetings are open unless otherwise indicated)

Senate

Committee on Banking, Housing, and Urban Affairs: to hold hearings to examine the nomination of Ben S. Bernanke, of New Jersey, to be Chairman of the Board of Governors of the Federal Reserve System, 10 a.m., SD–106.

Committee on Energy and Natural Resources: to hold hearings to examine H.R. 3276, to promote the production
of molybdenum-99 in the United States for medical isotope production, and to condition and phase out the export of highly enriched uranium for the production of medical isotopes, 10 a.m., SD–366.

Subcommittee on National Parks, to hold hearings to examine S. 760, to designate the Liberty Memorial at the National World War I Museum in Kansas City, Missouri, as the “National World War I Memorial”, S. 1838, to establish a commission to commemorate the sesquicentennial of the American Civil War, S. 2097, to authorize the rededication of the District of Columbia War Memorial as a National and District of Columbia World War I Memorial to honor the sacrifices made by American veterans of World War I, S. 2722, to authorize the Secretary of the Interior to conduct a special resource study to determine the suitability and feasibility of adding the Heart Mountain Relocation Center, in the State of Wyoming, as a unit of the National Park System, S. 2726, to modify the boundary of the Minuteman Missile National Historic Site in the State of South Dakota, S. 2738, to authorize National Mall Liberty Fund D.C. to establish a memorial on Federal land in the District of Columbia to honor free persons and slaves who fought for independence, liberty, and justice for all during the American Revolution, H.R. 1849, to designate the Liberty Memorial at the National World War I Museum in Kansas City, Missouri, as the National World War I Memorial, to establish the World War I centennial commission to ensure a suitable observance of the centennial of World War I, and H.R. 3689, to provide for an extension of the legislative authority of the Vietnam Veterans Memorial Fund, Inc. to establish a Vietnam Veterans Memorial visitor center, 2:30 p.m., SD–366.

Committee on Environment and Public Works: Subcommittee on Water and Wildlife, to hold hearings to examine S. 373, to amend title 18, United States Code, to include constrictor snakes of the species Python genera as an injurious animal, S. 1519, to provide for the eradication and control of nutria in Maryland, Louisiana, and other coastal States, S. 1421, to amend section 42 of title 18, United States Code, to prohibit the importation and shipment of certain species of carp, S. 1965, to authorize the Secretary of the Interior to provide financial assistance to the State of Louisiana for a pilot program to develop measures to eradicate or control feral swine and to assess and restore wetlands damaged by feral swine, H.R. 2188, to authorize the Secretary of the Interior, through the United States Fish and Wildlife Service, to conduct a Joint Venture Program to protect, restore, enhance, and manage migratory bird populations, their habitats, and the ecosystems they rely on, through voluntary actions on public and private lands, S. 1214, to conserve fish and aquatic communities in the United States through partnerships that foster fish habitat conservation, to improve the quality of life for the people of the United States, H.R. 3537, to amend and reauthorize the Junior Duck Stamp Conservation and Design Program Act of 1994, H.R. 3453, to amend the North American Wetlands Conservation Act to establish requirements regarding payment of the non-Federal share of the costs of wetlands conservation projects in Canada that are funded under that Act, and H.R. 509, to reauthorize the Marine Turtle Conservation Act of 2004, 2 p.m., SD–406.

Committee on Foreign Relations: to hold hearings to examine Afghanistan, focusing on assessing the road ahead, 9 a.m., SH–216.

Committee on Homeland Security and Governmental Affairs: to hold hearings to examine the nomination of Caryn A. Wagner, of Virginia, to be Under Secretary of Homeland Security for Intelligence and Analysis, 10 a.m., SD–342.

Committee on Indian Affairs: business meeting to consider pending calendar business; to be immediately followed by an oversight hearing to examine expanding dental health care in Indian Country; to be immediately followed by an oversight hearing to examine Contract Health Services, 2:15 p.m., SD–628.

Committee on the Judiciary: business meeting to consider S. 448, to maintain the free flow of information to the public by providing conditions for the federally compelled disclosure of information by certain persons connected with the news media, S. 714, to establish the National Criminal Justice Commission, S. 1624, to amend title 1 of the United States Code, to provide protection for medical debt homeowners, to restore bankruptcy protections for individuals experiencing economic distress as caregivers to ill, injured, or disabled family members, and to exempt from means testing debtors whose financial problems were caused by serious medical problems, S. 1765, to amend the Hate Crime Statistics Act to include crimes against the homeless, S. 1353, to amend title 1 of the Omnibus Crime Control and Safe Streets Act of 1986 to include nonprofit and volunteer ground and air ambulance crew members and first responders for certain benefits, S. 678, to reauthorize and improve the Juvenile Justice and Delinquency Prevention Act of 1974, and the nominations of Thomas I. Vanaskie, of Pennsylvania, to be United States Circuit Judge for the Third Circuit, Louis B. Butler, Jr., to be United States District Judge for the Western District of Wisconsin, Denny Chin, of New York, to be United States District Judge for the Second Circuit, Rosanna Malouf Peterson, to be United States District Judge for the District of Minnesota, Mary Elizabeth Phillips, to be United States Attorney for the Western District of Missouri, Sanford C. Coats, to be United States District Judge for the District of Kansas, William M. Conley, to be United States District Judge for the Eastern District of Washington, and Steven James Smith, to be United States District Judge for the District of North Carolina, 10 a.m., SH–216.

Select Committee on Intelligence: to hold closed hearings to consider certain intelligence matters, 2:30 p.m., S–407, Capitol.

House

Committee on Agriculture, Subcommittee on Conservation, Credit, Energy, and Research, hearing to review the
costs and benefits of agriculture offsets, 10 a.m., 1300 Longworth.

Committee on Armed Services, hearing on Afghanistan: The Results of the Strategic Review, Part I, 1 p.m., 210 HVC.


Committee on Financial Services, hearing on the following bills: H.R. 2266, Reasonable Prudence in Regulation Act; and H.R. 2267, Internet Gambling Regulation, Consumer Protection, and Enforcement Act, 10 a.m., 2128 Rayburn.

Committee on Foreign Affairs, Subcommittee on Africa and Global Health, hearing on Sudan: A review of the Administrations's New Policy and A Situation Update, 10 a.m., 2172 Rayburn.


Committee on the Judiciary, Subcommittee on the Constitution, Civil Rights, and Civil Liberties, hearing on the Civil Rights Division of the Department of Justice, 10 a.m., 2141 Rayburn.

Committee on Oversight and Government Reform, hearing entitled “Post-Katrina Recovery: Restoring Health Care in the New Orleans Region,” 10 a.m., 2154 Rayburn.

Committee on Science and Technology, Subcommittee on Energy and Environment, hearing on Marine and Hydrokinetic Energy Technology: Finding the Path to Commercialization, 10 a.m., 2318 Rayburn.

Subcommittee on Investigations and Oversight and the Subcommittee on Space and Aeronautics, joint hearing on Independent Audit of the National Aeronautics and Space Administration, 2 p.m., 2318 Rayburn.

Permanent Select Committee on Intelligence, Subcommittee on Technical and Tactical Intelligence, executive, briefing on NRO Facility Update, 10 a.m., 304 HVC.
Next Meeting of the SENATE
9:30 a.m., Thursday, December 3

Senate Chamber

Program for Thursday: Senate will continue consideration of H.R. 3590, Service Members Home Ownership Tax Act, vote on or in relation to Mikulski Amendment No. 2791 (to Amendment No. 2786), and Murkowski Amendment with respect to mammography at 11:45 a.m., and vote on or in relation to Bennet Amendment No. 2826, and McCain motion to commit at 2:45 p.m.

Next Meeting of the HOUSE OF REPRESENTATIVES
10 a.m., Thursday, December 3

House Chamber

Program for Thursday: Consideration of H.R. 4154—Permanent Estate Tax Relief for Families, Farmers, and Small Businesses Act of 2009 (Subject to a Rule).

Extensions of Remarks, as inserted in this issue

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