

were willing to give everything for us. They should get the benefits they have earned. From the beginning I have been working to restore this cut to their COLA benefits. I have been very happy we have a bipartisan agreement to move forward and ensure we keep our promise to them.

I come to the floor today to also talk about rural veterans and a rural veterans improvement act. I was proud to introduce this bill with Senator HELLER from Nevada earlier this week. When it comes to veterans' health care, we know there are challenges. We know we can do better, and we know we have to do better.

Over 6 million veterans live in rural areas, including approximately one-third who fought in Afghanistan and Iraq. Three million of those rural veterans receive health care through the VA. Our veterans have fought halfway around the world for our freedom. We should go the extra mile for them.

Senator HELLER and I both come from rural western States. We know the difficulties veterans face when distances are too far and choices are too few. Our legislation would do four things: improve access to mental health services, expand transportation grants, hire and retain more medical professionals in rural areas, and give Congress and the VA tools to improve the quality of rural facilities.

First, let me start with mental health care. This is crucial. Veterans are struggling when the help they need is not available or is very far away.

One of my constituents lives in a rural area in northern New Mexico. He fought in Vietnam and was diagnosed with post-traumatic distress disorder. He required therapy 2 full days a week for 2 years. This vital care probably saved his life. The VA was there for him, and he is grateful, but he had to drive to Albuquerque, over 3 hours away, to get that essential care.

The veterans in my State are clear: They need better access to treatment and more mental health options. One size does not fit all. Conventional therapy does not work for everyone. Veterans groups, such as the Wounded Warrior Project, have long supported alternative treatments and more holistic methods. Tribal governments are also working with the VA to use traditional Native American healing techniques, helping their veterans with PTSD and other diagnoses.

These veterans are in pain. They are at increased risk of suicide. Help has to be there when they need it. Our bill would enable the VA to work with non-VA fee-for-service providers for veterans with service-connected mental health issues when conventional treatment is not available or where alternative treatment is not an option.

Second, even the best health care is useless if you cannot get to it. I have talked with many veterans in my State about this issue, and it is a big problem across New Mexico. Veterans in Carlsbad face a 6-hour drive to the VA hos-

pital in Albuquerque, 300 miles away one way. One such veteran fought bravely in World War II. He is now in his eighties. He has to get up at 5 a.m. and make the trip to Albuquerque to see medical specialists. Sometimes he doesn't get home until midnight. Thanks to the great volunteer drivers at Southeast New Mexico Veterans Transportation Network, he is able to get there, but it is an exhausting day.

Another of my constituents recently retired to Chama, NM, a rural community in the north. He and his wife built a home there, looking forward to retirement. The VA outreach clinic was nearby, but its contract was not renewed and it closed. His only option now is the VA clinic in Espanola, 80 miles each way through the southern Rockies. When winter storms come, as they do in northern New Mexico, he may not be able to get there at all.

The VA offers transportation grants to help, but only for veterans in what they call highly rural areas with fewer than seven people per square mile, not for those in rural areas and small towns such as Chama, and the small towns in Nevada and so many other States. They need help too. The miles are just as long and the journey is just as hard.

Our bill will help by expanding VA transportation grants to include rural communities, and it will not require matching funds for grants up to \$100,000, making it easier for these communities to apply for assistance.

Third, rural VA clinics, as their private counterparts, have trouble getting staff and keeping staff. This is not news to veterans who see constant turnover of doctors and nurses and other health care professionals or who have to travel long distances to see anyone at all.

Our bill will establish a VA training program, working with university medical centers to train health care professionals, serving rural veterans at outpatient clinics. Those who complete the program and a 3-year assignment will receive a hiring preference for jobs with the Veterans Health Administration.

We also propose a pilot program for housing incentives for health care professionals to work in rural VA facilities. We are proposing that the VA streamline the hiring of military medical professionals, transitioning to the civilian world into the VA system.

Rural VA health centers have a big job. They do their best. We have to do all we can to help them to get and keep staff with incentives, training, and innovation. It is not easy, but it is essential.

Fourth, we call for a full review of VA community-based outpatient clinics in rural and highly rural areas so we can prioritize expansions and improvements, making sure dollars are well spent and resources go as far as possible. We also call for a report to Congress on whether to add polytrauma centers in rural areas to

help veterans from Iraq and Afghanistan recover from multiple major injuries such as serious burns and traumatic brain injuries.

Every day, American servicemembers wake up far from home, and every day, they stand watch. They do the job they promised to do—and not only if it is easy or only if it is convenient. We owe them the same promise. Rural veterans should not be left behind. They should get the care they need and deserve.

Again, I thank Senator HELLER for working with me on this bill. He understands the problem. He is committed to finding solutions.

Our bill is a step forward for the health and well-being of our veterans. This is about essential care, about access, about honoring our commitment to the men and women who have sacrificed so much for our community. I urge my colleagues to support the bill.

Madam President, I ask unanimous consent that Senator DURBIN be recognized to speak immediately after me.

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

Mr. UDALL of New Mexico. I see Senator DURBIN on the floor.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Madam President, I thank the Senator from New Mexico.

(The remarks of Mr. DURBIN pertaining to the introduction of S. 2023 are printed in today's RECORD under "Statements on Introduced Bills and Joint Resolutions.")

Mr. DURBIN. Madam President, I yield the floor and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BLUNT. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

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

#### HEALTH CARE

Mr. BLUNT. Madam President, I want to talk a little bit about the letters I have received and the messages we have received in the office in the last week regarding the changes we see going on in health care. There was quite a bit of discussion last week about how health care impacts the workplace, and I think a lot of misinformation is out. The Congressional Budget Office projection, as some people have alleged, does not say that 2 million more people are going to have part-time jobs. It says the equivalent job loss because of the Affordable Health Care Act is the equivalent of 2.3 million people losing full-time jobs. That may mean that 10 million people who otherwise would have had full-time jobs have part-time jobs.

The other thing is, it is three times as big as the number that was on the table when people voted for the Affordable Care Act. At that time, the Congressional Budget Office said: If this

law passes, there will be 800,000 fewer jobs than if this law does not pass. The collective impact on the economy is 800,000 fewer jobs.

Last week they said there would be 2.3 million fewer jobs—roughly three times the amount that the earlier estimate was. Similar to so many other estimates in this law, the reality of the law turns out to be different than the estimates. Surely that was an estimate that nobody wanted. I cannot imagine anybody who voted for this bill—and I did not vote for it—but I cannot imagine anybody who voted for this bill thought: That is a really great thing. We are going to lose 800,000 jobs if this bill passes. I assume they thought: The good this bill will do will offset losing 800,000 jobs.

Now we find out it is 2.3 million jobs and all kinds of information that the good that was supposedly going to be done is not what people had hoped for.

While we are talking about the workplace, I have a letter from a person who is the president of one of our community colleges in the State of Missouri. He says because of the Affordable Care Act “we have reviewed all part-time employment to ensure compliance with the Affordable Care Act . . . which defines full-time as 30 hours or more per week. Without specific guidance in converting credit hours to clock hours, we have reduced part-time faculty’s teaching loads to ensure” nobody works more than 30 hours.

This is not the only letter or contact all of us have had on this topic. We know the unintended consequence of this law on the workplace is that people are now told whom they do not have to insure. State governments, community colleges, big companies all looking at a law for the first time that supposedly says whom you have to insure—though the President certainly feels he has the authority that none of us can find anywhere in the law to decide when the law is going to go into effect and when it is not—but the law says whom you have to insure, and suddenly people who for a long time have provided health care benefits because they thought it was the right thing to do or the competitive thing to do now respond to this directive from the Federal Government that says what you have to do, and that means that is all you have to do.

So all of these employees who may have worked 25 hours, 28 hours, 32 hours in the past who all got insurance now are suddenly working less than 30 hours. I have talked to enough of these employees to know this is not because they do not want to work more; this is not because they want to make less money; this is not because they want to teach one less class; it is because the law has had that kind of impact on the workplace.

The other promises—we are going to get better coverage for less cost—surely, somebody is getting better coverage for less cost. But my guess is that is a much smaller group than the people

who are losing their insurance and because of the so-called broader and better coverage have more costs.

Here is a letter from Kathy in Wentzville, MO. She says:

I carry insurance through a large corporation and my premium increased this year because the minimum standards [in the law] affect my plan.

Premiums increased by 25 percent.

She goes on, in no uncertain terms, to suggest that she does not like the Affordable Care Act or think it is affordable.

Jeff from St. Joseph said:

Thank you for the opportunity to share my family’s opinion on ObamaCare. First off I would like to state that we have experienced increases in our health insurance. My employer’s insurance has doubled of which I pay ½. My family’s separate insurance policy has risen as well with a cancellation due in December. I have considered canceling my [own] health insurance through my employer so that I could provide for my family’s [health insurance at their new rates].

This is a family that a few months ago thought they were going to be able to continue to keep what they had. They liked what they had. They thought they could afford what they had. Now they are deciding who is going to go without insurance so other people can have insurance in the family at the higher rate.

William from St. Louis, MO, says:

My insurance was canceled in December.

He says:

. . . my insurance rates have been drastically increasing each year since the law was passed.

Four years ago, I had a policy for my family with a \$500 deductible and the ability to go to any hospital/doctor in St. Louis for \$1,000 per month. Now I have a policy with a \$2,000 deductible and I can’t go to [the doctor I used to go to].

He says his policy now—that does not allow him to go to the doctor he used to go to—does not cost \$1,000 a month any longer; it costs \$1,500 a month.

Ted in St. Joseph said his doctor has changed the way he does business. He says his doctor has downsized the types of plans he accepts and is moving to a customer base with higher incomes.

So Ted’s doctor, according to Ted in St. Joseph, has stopped taking patients with Blue Cross/Blue Shield because of increased costs, and Ted, who by the way liked the doctor he had, now has to find another doctor who will take the coverage he can get.

Steve, in St. Joseph, and his wife are raising their 14-year-old grandson, and all three have seen their insurance costs increase—they think because of the Affordable Care Act. His grandson’s policy went up \$50 a month, from \$104 to \$154. His wife’s deductible went from \$1,000 per year to \$5,000 per year and her insurance costs over \$800 a month.

He goes on to say—and I thought about whether I should read this; I assume they have talked about this too. He said: “If we were to get divorced, her premium would be less than \$200 per month.” I think Steve is not suggesting that he and his wife should get

divorced, but he is just talking about, again, the unintended consequences. A family who is together cannot afford to have the coverage they had. Her coverage is \$800 a month, but as a substitute teacher—I believe that is what this letter says she does—her income would qualify her for a \$200-a-month policy instead of the \$800 they are paying now.

Sandy from Armstrong, MO, says she received a letter from her insurance company notifying her that her premiums were about to increase. She went on healthcare.gov to find plans she and her husband could qualify for, and the plans she found were double the premiums she had been paying.

Kelly from Farmington, MO, works in the HR department, the human resources department, at a bank. She feels healthy groups will be paying more for insurance because of the ACA and because of the expanded coverage.

Her department has received many questions, she says, about health care coverage but feels limited in how much they can tell anybody because they do not know how the new law is going to apply.

The law of unintended consequences continues to be the law that applies here. Missourians and people all over the country are contacting us and asking how much damage we are willing to do to the health care system that was working to get more people included in that system. There were ways to do this, every one of which I believe was legislatively proposed in 2009—small changes that would have made a big difference in a health care system that was working for people who were in that system. We needed to figure out the few ways to get more people in that system. Instead, we have had a dramatic impact on the best health care system in the world, and people are beginning to figure that out.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DURBIN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

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

#### UNANIMOUS CONSENT AGREEMENT—EXECUTIVE CALENDAR

Mr. DURBIN. Madam President, I ask unanimous consent that upon disposition of the House message with respect to S. 25, the Senate proceed to executive session to consider the following nominations: Calendar Nos. 497, 498, 493, 494, 495, 496, 531, and 534; that the Senate proceed to vote without intervening action or debate on the nominations in the order listed; that the motions to reconsider be considered made and laid on the table, with no intervening action or debate; that no further motions be in order; that any related statements be printed in the